

PLAN YEAR 2004



**Personnel Cabinet
Public Employee
Health Insurance Handbook**

**Attention Employees of
Boyd, Carter, Elliott, Greenup,
Henderson, Lawrence and Union Counties.**

At the time this Handbook was printed, the carrier availability for Boyd, Carter, Elliott, Greenup, Henderson, Lawrence and Union Counties had not been finalized. Once carrier availability has been finalized for these seven counties, the Office of Public Employee Health Insurance (OPEHI) will produce a separate document and mail it directly to employees living and working in the above counties.

We do not anticipate the need to change the dates of Open Enrollment for these seven counties. However, if that becomes necessary, the affected employees will be notified at the time they receive the additional availability information. If the affected employees do not receive this information by September 15, 2003, they should contact their Insurance Coordinator immediately.

We apologize for any inconvenience this may cause. If you have any questions, please contact the OPEHI's Member Services Branch at (888)581-8834.

For Your Record

This Health Insurance Handbook has been created as a resource for your use not only during Open Enrollment but also during the year. Use this page to keep a record of anyone you may have talked with during Open Enrollment. This page is provided for your personal documentation and is in no way binding in the event of inconsistency with your application.

Agency Health Insurance Coordinator	Phone #	Date of Call
Carrier Contact	Phone #	Date of Call
OPEHI Contact	Phone #	Date of Call

Did you have to complete and turn in an application? If so, to whom did you give the application and on what date?

What carrier and plan type did you choose?

What county did you use to select your coverage?

What deduction will be taken from your check each month? Will the deduction be taken once or twice a month?

Keep this Handbook and your copy of any applications you may have completed during Open Enrollment. This Handbook should be utilized throughout the year for any questions you may have.

For Your Information – Mistakes to Avoid

Please read the following list of errors most frequently committed by our employees for 2003.

Not meeting deadlines

Open Enrollment applications must be signed and submitted to your Health Insurance Coordinator by the date listed on page 12. Employees who experience a Qualifying Event are required to submit the necessary paperwork within certain timeframes. Failure to do so resulted in the request being denied.

Solution

For Open Enrollment, do not wait until the last day to make your decision.

- Review this handbook;
- Complete the 2004 Benefit Planner;
- Make your decision;
- Complete and sign the application; and
- Submit it to your insurance coordinator prior to the end of Open Enrollment.

For any change during the year, review pages 38-39 for a list of the most common Qualifying Events. This Section tells you the timeframes and what you must do. If you experience a Qualifying Event that is not listed, review the list on our website or contact the OPEHI's Member Services Branch for additional information.

Financial Hardship

Some employees did not consider making changes to their health insurance during Open Enrollment because their current carrier was still offered in their county of choice. Further, employees did not review the rates for the new plan year, and when the premiums were deducted from their paychecks for the new plan year, the employees realized the premium was unaffordable.

Solution

Use the 2004 Benefits Planner on page 10 to determine the premiums that will be deducted from your paycheck.

Spouse has a different Open Enrollment Period than the Public Employee Health Insurance Program

The employee's spouse worked for an employer that did not participate in the Public Employee Health Insurance Program, and had a different Open Enrollment period. The employee wanted to make corresponding changes, including redirecting the employer contribution.

Solution

The employee will be permitted to make corresponding changes to his/her Public Employee Health Insurance Program selections, including redirecting the state contribution, **IF** those changes are made prior to 12/31/03. Due to the federal

regulations, any requested changes (based on “different Open Enrollment”) made after that date will be denied.

Spouse gains or loses employment that offers group health insurance

This is a Qualifying Event that would have allowed an employee to make a change in their health insurance. However, the employee wanted to make changes based on the date the spouse gained or lost employment, rather than the date the spouse gained or lost eligibility based on employment.

Solution

When the member’s spouse gains or loses employment, the Qualifying Event date is the date coverage will be gained or lost. Insurance is based on gaining or losing eligibility. Therefore, the OPEHI will not make the change until coverage is gained or lost.

Doctors, hospitals or other providers do not participate with your carrier

Members did not realize their doctors no longer participated with the selected carrier or a participating doctor (provider) canceled participation during the year.

Solution

Provider Directories are subject to change regularly. Before you make your decision, check with each of your doctors to ensure they participate with the carrier. Be specific regarding the plan choice (PPO, HMO or POS) you are going to take with a particular carrier. A provider may participate with a carrier’s HMO plan and not the PPO plan. Ask the provider if they plan to participate throughout the year. The OPEHI cannot dictate that a provider participate with a carrier. If your doctor ceases participation in the plan, that is not a Qualifying Event to change plans.

Waiving Health Insurance

Prior to 2004, an employee had to waive health insurance annually. Failure to do so resulted in the employee being assigned to health insurance coverage (lowest cost Single Option A). Frequently, the employees failed to waive their health insurance, but would complete the Flexible Spending Account (FSA) application. The result was that the employee was not eligible to direct the employer contribution into that Health Care Flexible Spending Account.

Solution

Beginning with the 2004 Plan Year, waivers will carry-over from one year to the next. For example, if you are currently waiving health insurance coverage and you want to continue waiving for 2004, you will **not** need to complete a new health insurance application for waiver. However, you will still have to complete the application for the Health Care Flexible Spending Account.

Table of Contents

Notice to Employees of Boyd, Carter, Elliott, Greenup, Henderson, Lawrence and Union Counties	ii
For Your Record	iii
For Your Information – Mistakes to Avoid	iv
How Do I use this Handbook	9
2004 Benefits Planner	10
Open Enrollment Information	11
Annual Open Enrollment Period	12
2004 Benefit Fair Schedule	13
New and/or Changes for 2004	14
Application	14
Cross-Reference	14
Elimination of Automatic Assignment	14
Wavier Continuation	14
Waiving Health Insurance and Flexing the Employer Contribution – State Agency Employees	14
Waiving Health Insurance and Flexing the Employer Contribution – All other Employees	14
Contiguous County Selection	15
Newborns	15
Changes for 2004	15
Benefit Change	15
Service Area	15
General Information Regarding Open Enrollment	15
Effective Dates	16
Termination Dates	16
Do I have to Do Anything During Open Enrollment? What?	17
What if I Do Nothing	18
2004 Health Insurance Rates	19
2004 Availability Chart	20
Eligibility	23
What Is The Monthly Employer/Retirement Contribution	24
Employer/Retirement Contribution	24
Active Employees only	24
Payment Options	24
Paying your premiums with tax free dollars (Premium Conversion)	24
New Employee Information	25
As a new employee, what must I do?	25
What if I do not enroll in health coverage when I am first eligible?	25
When is my coverage effective	25
If I do not use my employer contribution (\$234), can I use that money in a Flexible Spending Account?	25
Who is Eligible to Participate in the Public Employee Health Insurance Program?	26
Eligible Participants	26
Who can you cover under your state-sponsored health plan?	26
Dependent Children Turning 24	27

Can I Waive (Decline) My Health Insurance Coverage?	28
If I waive coverage, what will happen to the employer contribution?	28
What Level of Coverage is Right for Me	29
Single	29
Parent Plus	29
Couple	29
Family	29
Payment Options	29
Monthly	29
Twice Monthly	29
Cross-Reference	29
Which County Can I Use to Select my Coverage?	31
County of Residence	31
County of Employment	31
Contiguous County	31
Contiguous County Map	33
Qualifying Events	31
What if I want to Make Changes in my Health Insurance Outside of Open Enrollment	35
Effective Dates – Qualifying Events	35
Termination Dates – Qualifying Events	35
Qualifying Events Information	36
Supporting Documents needed for Qualifying Events	37
Divorce/Legal Separation/Annulment	37
Adoption/Placement for Adoption	37
Judgment, decree or administrative order relating to health coverage for your child	37
Employee, Spouse or dependent enrolled in Employer’s health plan becomes entitled to Medicare or Medicaid	37
Loss of other group health insurance coverage that entitles employee or family member to be enrolled in accordance with HIPAA	37
Qualifying Event Chart	38
COBRA	40
COBRA Rights	41
What is COBRA	41
Definition of Qualified Beneficiary	42
Electing COBRA	42
Premiums	42
Your Responsibilities	43
Duration of COBRA Coverage	43
Open Enrollment	44
Proof of Prior Health Coverage/Preexisting Conditions	44
Employees with Disabilities	44
Plan Options	46
Important Information Regarding YOUR Benefits	47
Which Option is Best for You?	47
Provider Information	47
Balance Billing	47
Out of Service Area Dependent Coverage	47
Pre-existing Conditions	48

Co-payments, Co-insurance and Maximums	48
Medical Services	48
Preventive Services	48
Reminders	49
PPO	50
HMO	52
POS	54
EPO	56
What About Prescription Drug Coverage	58
Mail Order Prescription Drug	58
Prescription Drug Coverage	58
75 Prescription Rule	59
Exclusion of Benefits	61
Bluegrass Family Health Carrier Page	62
CHA Health Carrier Page	63
Humana Carrier Page	64
General Information	65
What is the Health Insurance Portability and Accountability Act (HIPAA)?	66
HIPAA	66
HIPAA and the OPEHI	66
HIPAA Authorization Form (Sample)	67
What about Flexible Spending Accounts	68
Grievance and/or Appeals Procedures to the Health Insurance Carrier	69
Grievances to the Public Employee Health Insurance Program's Grievance Committee	70
Terms You Need to Know	71
Retiree Information	73
Important Information for Retirees	74
Retirees of the Kentucky Judicial Retirement Plan (JRP) and Kentucky Legislators Retirement Plan (LRP)	77
Retirees of the Kentucky Retirement Systems	79
Retirees of the Kentucky Teachers' Retirement System	84
Helpful Phone Numbers and Websites	86

How do I use this handbook?

This Health Insurance Handbook has been provided to help you understand what insurance options are available. Health insurance is one of your most valuable employee benefits. Familiarize yourself with the topics in this handbook and recognize your responsibility regarding eligibility and enrollment requirements. We hope you will find this information helpful, useful and easy to understand.

The Office of Public Employee Health Insurance (OPEHI) within the Personnel Cabinet is responsible for administering the Public Employee Health Insurance Program. Please contact OPEHI if you have any questions regarding your health insurance for 2004.

FAILURE TO MEET THE PLAN REQUIREMENTS MAY RESULT IN DENIED CLAIMS OR A BENEFIT REDUCTION TO YOU. READ THIS HANDBOOK AND YOUR CERTIFICATE OF COVERAGE (MEMBER HANDBOOK FROM YOUR CARRIER) CAREFULLY.

Phone Numbers and Website

If you need help with information contained in this handbook, please contact the OPEHI's Member Services Branch at (888)581-8834 (outside Franklin County) or (502)564-6534 (in Franklin County).

Please visit the OPEHI's website which is located at <http://personnel.ky.gov/opehi.htm> for the most up-to-date information regarding the Public Employee Health Insurance Program. Additional information may be posted throughout the year. Further, links to the various health insurance carriers' websites are also provided on our website.

MAKE SURE YOU READ THE ENTIRE HANDBOOK.

Your Health Insurance Handbook is a guide to making an informed choice for health insurance coverage. Compare the plans carefully.

1. Read through the "New And/or Changes for 2004" (pages 14-15) for a quick overview of the changes.
2. Review the Plan Types and Benefit Grids on pages 50-57 to determine the type of plan that will best meet your medical needs.
3. Review the availability chart on pages 20-22 to check plan availability in either the county where you live, work or, if applicable, a contiguous county (refer to pages 31-33).
4. Review the rate chart on page 19 to check the cost of the health insurance plan you have chosen for 2004.

2004 Benefits Planner

County Selection: _____

Carrier Selection (circle): Anthem Bluegrass CHA Humana

Plan Selection (circle): PPO HMO POS EPO

Option Selection (circle): A B

Coverage Selection (circle): Single Parent Plus Couple Family

Payment Selection (circle): Monthly Twice Monthly* Couple Cross-Reference*
Family Cross-Reference*

<p>Monthly Cost of Plan Selection (see page 19)</p>		<p>(A)</p>
<p>Enter Employer Contribution for County Selection (see pages 20-22)</p>	<p>(B)</p>	<p></p>
<p>If applying for Cross-Reference, enter Employer Contribution for spouse</p>	<p>(C)</p>	
<p>Total Employer Contribution (Add lines B and C)</p>		<p>(D)</p>
<p>Subtract Line D from Line A. This is the total monthly employee cost.</p>		<p>(E)</p>
<p>If you selected the twice monthly payment option, divide line E by 2. This is the amount that will be deducted from each paycheck received beginning in December 2003.</p>		<p>(F)</p>
<p>If you are applying for Cross-Reference, divide line E by 2. This is the amount that will be deducted monthly from each spouse's paycheck beginning in December 2003.</p>		<p>(G)</p>
<p>If you are applying for Cross-Reference and have elected the twice monthly payment option, divide line E by 4. This is the amount that will be deducted twice monthly from each spouse's paycheck beginning in December 2003.</p>		<p>(H)</p>

This form may not be applicable to all agencies

*If applicable

OPEN ENROLLMENT INFORMATION

**HEALTH INSURANCE
ANNUAL OPEN ENROLLMENT PERIOD
PLAN YEAR 2004**

ACTIVE EMPLOYEES

SEPTEMBER 15 – OCTOBER 3, 2003
(Deadline to turn in your application to your Health
Insurance Coordinator is
October 3, 2003)

RETIREES

SEPTEMBER 15 – OCTOBER 17, 2003
(Deadline to turn in your application to the
appropriate Retirement System is
October 17, 2003)

COBRA PARTICIPANTS

SEPTEMBER 15 – OCTOBER 17, 2003
(Deadline to turn in your application to your
health insurance carrier is
October 17, 2003)

**Plan Year 2004
Benefit Fair Schedule**

County	Date/Time	Location
Christian County	September 15 2:00 pm – 6:00 pm	Pennyryle Area Dev District Office 300 Hammond Drive Hopkinsville, KY
Daviess County	September 18 2:00 pm – 6:00 pm	Owensboro National Guard Armory 1501 Parrish Ave Owensboro, KY
Fayette County	September 25 3:00 pm – 6:00 pm	Paul Dunbar H.S. Cafeteria 1600 Man O War Blvd Lexington, KY
Franklin County	September 24 8:00 am – 6:00 pm	Farnham Dudgeon Civic Center Arena Floor Frankfort, KY
Jefferson Country	September 17 8:00 am – 6:00 pm	Kentucky Fair & Exposition Center West Wing, West Hall Rms. 1 & 2 Louisville, KY
Kenton County	October 1 2:00 pm – 6:00 pm	N. KY Area Dev District 22 Spiral Drive Florence, KY
McCracken County	September 16 2:00 pm – 6:00 pm	Western KY Community & Technical College Crounse Hall Atrium 4810 Alben Barkley Drive Paducah, KY
Perry County	September 23 4:00 pm – 6:00 pm	Perry Co Central HS 305 Park Ave Hazard, KY
Pike County	September 22 3:00pm – 6:00 pm	Pike Central High School 100 Winners Circle Drive Pikeville, KY
Pulaski County	October 2 2:00 pm – 6:00 pm	Somerset Community College Meece Hall Student Lounge Somerset, KY
Rowan County	September 30 2:00 pm – 6:00 pm	Morehead State University Academic Ed Bldg Morehead, KY
Warren County	September 29 2:00 pm – 6:00 pm	Bowling Green Technical School Building F, 1845 Loop Drive Bowling Green, KY

New and/or Changes for 2004

New for 2004

Application

The Health Insurance Application has changed for 2004. For state agency employees, the Health Insurance and Commonwealth Choice applications have been combined.

Cross-Reference

If you and your spouse work for an agency participating in the Public Employee Health Insurance Program and you wish to cross-reference, you will no longer be required to complete two separate applications. Both spouses will sign one application. Each will be responsible for having his/her Insurance Coordinator sign the application. The policyholder will be the person listed in Section I of the application. See page 29-30 for additional information regarding cross-reference.

Elimination of Automatic Assignment

The Commonwealth will no longer automatically assign employees to the lowest cost Single Option A plan. If you are required to make a change in your health insurance for 2004 (i.e., your carrier is no longer available), and you fail to complete the necessary application, **you will NOT have health insurance coverage for 2004**, and will not be allowed to enroll until the next Open Enrollment, unless you experience a Qualifying Event that would allow you to enroll.

Waiver Continuation

If you waived your health insurance for 2003, and wish to waive your health insurance for 2004, it will NOT be necessary to complete a new application. The current waiver will carry-over from one year to the next; however, you must complete a new Flexible Spending Account (FSA) application to continue participating in the FSA program. See page 68 for additional information regarding the FSA programs.

Waiving Health Insurance and Flexing the Employer Contribution – State Agency Employees

For state agency employees only, if you are waiving coverage and wish to direct the employer contribution (\$234) into a Health Care Flexible Spending Account, you must complete Sections I, II #2, VI and VII. You must enter “999” as the Plan Code in Section II #2. A separate Flexible Spending Account application is no longer required for Commonwealth Choice.

Waiving Health Insurance and Flexing the Employer Contribution – All other Employees

For non-state employees, if you are waiving coverage, you must complete the appropriate Flexible Spending Account application, which is available from your Agency’s Health Insurance Coordinator.

Contiguous County Selection

Legislation was passed during the 2003 Legislative Session amending the contiguous county selection. If an employee's residence and place of employment are each located in counties marked "contiguous counties" (see map on page 33), the employee may select a plan available in his/her work county, home county or the county contiguous to his/her home county that is highlighted in yellow on the Contiguous County map on page 33. For additional information on Contiguous County Selection, refer to page 31-33.

Newborns

Coverage for newborns is effective on the date of birth, if the application is completed and signed no later than 60 days of the date of birth. If the employee signs the application on or after the 61st day, and prior to the 120th day of the birth, the child will be added effective the first day of the first month following the signature date on the application (i.e. the baby is born January 1, the application is signed March 15, the child will be covered April 1). If the application is not signed within the 120 days, the baby cannot be added until the next Open Enrollment period, unless you experience an appropriate Qualifying Event that would allow a change. Remember, if you wish to add other dependents as a result of the birth, you must complete the application no later than 30 days of the date of birth.

Changes for 2004

Benefit Change:

The only benefit change for 2004 is an increase in the number of prescription co-payment/co-insurance the employee will have to pay before the co-payment/co-insurance is reduced. The change is from 50 to 75. For additional information regarding the 75 Prescription Rule, refer to pages 59-60.

Service Area

The service area and plan availability (PPO/HMO/POS) for most carriers has changed. Be sure to check the availability of your carrier and your current plan in the county where you live, work or, if applicable, a contiguous county (refer to pages 31-33). If your current carrier is no longer available in the county where you have selected your health insurance, or doesn't offer your current plan type, you **MUST** complete a new application to change carriers or change your county selection, if applicable. Failure to do so will result in a loss of health insurance for 2004.

General Information Regarding Open Enrollment

- Persons wishing to make ANY change (including but not limited to: changing county selection, adding or removing dependents, changing levels of coverage, changing carriers, changing payment option or enrolling for the first time) in their health insurance coverage **MUST** complete a new application for 2004.

- If you wish to participate, or continue to participate, in a Flexible Spending Account (FSA), you **MUST** complete the appropriate FSA enrollment form. Except for state employees, this form is separate from your health insurance application. **Retirees are not eligible for participation in the Flexible Spending Accounts.**
- For active employees, applications signed after October 3, 2003 will not be accepted. For retirees of the KCTCS Retirement Plan, Kentucky Judicial Retirement Plan, Kentucky Legislators Retirement Plan, Kentucky Retirement Systems and Kentucky Teachers' Retirement System, applications signed after October 17, 2003 will not be accepted.

Effective Dates

Any changes made during Open Enrollment, or any dependents added to your existing plan during Open Enrollment, will be effective January 1, 2004.

Termination Dates

Dependents dropped from your plan during this Open Enrollment period will be covered until December 31, 2003.

Dependents dropped during Open Enrollment are NOT eligible for COBRA, unless the reason for removal is a COBRA Qualifying Event.





Do I Have to do Anything During Open Enrollment? What?

YES, making sure you and your family have the health insurance coverage needed during 2004 is your responsibility. There are certain things that you **MUST** do during Open Enrollment to ensure you have the health insurance you desire. Failure to review your health insurance options may result in you and your family not being covered at all. **Use the following checklist while making a decision about your health insurance for 2004.**

- Review your current health insurance choices and the county in which you selected coverage (live, work or, if applicable, contiguous county). It is very important that you know this information. For example, if you selected your health insurance in the county in which you live, your carrier may not be available in that county in 2004, but it may be available in the county in which you work. If so, you **MUST** complete a new application to change your county selection. If you were required to complete an application during Open Enrollment and you failed to do so, you will not be covered in 2004.
- See pages 20-22 of this handbook to review which carriers are available in the county where you live, work or if applicable, a contiguous county (see pages 31-33).
- Compare the benefits of each plan type: PPO, HMO, POS and EPO. Decide which one best meets your needs. See pages 50-57 for a description of each plan type.
- Check the rate chart on page 13 of this handbook. **Premiums have changed.**
- Check the provider directory for each of the carriers available in the county where you live, work or, if applicable, a contiguous county (see pages 31-33) to see if your current doctor(s) participates with that carrier.
 - Call the doctor(s) of your choice to verify that he/she is still a participating provider with your specific plan, as provider directories are subject to change.
 - Be specific when calling your doctor. Specify the product (PPO, HMO, POS, or EPO).
 - Carriers may have different networks for different products. A doctor may not participate in all products.
 - Providers may discontinue participating with carriers at any time during the year. **This is not considered a Qualifying Event for purposes of changing your health insurance coverage.**
- It is important to get a copy of the new drug formulary (or preferred drug list) for 2004 from the carriers you are considering. This formulary is subject to change during the plan year with a 30-day notice to affected employees/retirees.
- Use the 2004 Benefits Planner located on page 10 to determine your cost of the plan selected.
- Complete the appropriate applications, if applicable, and turn your application in to your Insurance Coordinator prior to the end of Open Enrollment.

What if I Do Nothing?

What will happen if I do not complete an application during Open Enrollment for Plan Year 2004?

If you currently:	and you DO NOT complete the appropriate forms during Open Enrollment,	then on January 1, 2004, you will:
waive coverage		continue to waive coverage.
participate in a Flexible Spending Account Program		not be enrolled in the Flexible Spending Account Program for 2004, and deductions will not be taken.
are enrolled with a carrier that is no longer available in the county in which you selected coverage		not have coverage for 2004
are enrolled with a carrier that will still be offered in your selected county for 2004		remain covered through that same carrier and the same plan at the same level of coverage. Deductions taken from your paycheck will change accordingly.

There are many changes in carrier availability for 2004. Carrier rates have changed. Be sure to read all information in this handbook and any information you receive from the carriers prior to making your decision.

2004 Health Insurance Rates

Once you have selected a plan, enter the three (3) digit code number that corresponds to that plan on the application in the boxes provided in Section II, #2, Plan Code. If you waive your health insurance, you must enter 999 in Section II, #2. For employer/retirement contribution information, see pages 20-22.

CODE	HMO	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
091	Bluegrass Family Health	371.28	334.16	556.92	501.24	835.40	751.88	928.20	835.40
101	CHA Health	380.48	342.56	570.72	513.84	856.08	770.76	951.20	856.40
151	Humana – MBP	341.20	307.20	511.80	460.80	767.72	691.20	853.00	768.00

CODE	POS	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
092	Bluegrass Family Health	467.64	420.88	701.48	631.32	1052.20	947.00	1169.12	1052.20
102	CHA Health	428.16	385.28	642.24	577.92	963.36	866.88	1070.40	963.20
162	Humana	561.32	505.20	842.00	757.88	1263.00	1136.72	1403.36	1263.04

CODE	PPO	SINGLE		PARENT PLUS		COUPLE		FAMILY	
		A	B	A	B	A	B	A	B
093	Bluegrass Family Health	288.36	259.52	432.56	389.32	648.88	584.00	720.96	648.88
103	CHA Health	312.00	280.80	468.00	421.20	702.00	631.80	780.00	702.00
143	Humana	286.16	257.56	429.24	386.36	643.88	579.52	715.40	643.92

THERE ARE NO OUT-OF-NETWORK SERVICES FOR THE EPO PLAN.

CODE	EPO	SINGLE	PARENT PLUS	COUPLE	FAMILY
095	Bluegrass Family Health	227.84	341.76	512.64	569.60
105	CHA Health	254.88	382.32	573.48	637.20
145	Humana PPO	215.00	322.52	483.76	537.52

Code	
999	Waiver

Commonwealth of Kentucky
Healthcare 2004
Availability Chart

	Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	091	092	093	095	101	102	103	105	151	162	143	145	
1 - Adair													\$ 286.16
2 - Allen													\$ 286.16
3 - Anderson													\$ 286.16
4 - Ballard													\$ 286.16
5 - Barren													\$ 286.16
6 - Bath													\$ 288.36
7 - Bell													\$ 286.16
8 - Boone													\$ 286.16
9 - Bourbon													\$ 288.36
10 - Boyd													
11 - Boyle													\$ 286.16
12 - Bracken													\$ 286.16
13 - Breathitt													\$ 286.16
14 - Breckinridge													\$ 286.16
15 - Bullitt													\$ 286.16
16 - Butler													\$ 286.16
17 - Caldwell													\$ 286.16
18 - Calloway													\$ 288.36
19 - Campbell													\$ 312.00
20 - Carlisle													\$ 286.16
21 - Carroll													\$ 286.16
22 - Carter													
23 - Casey													\$ 286.16
24 - Christian													\$ 286.16
25 - Clark													\$ 286.16
26 - Clay													\$ 288.36
27 - Clinton													\$ 286.16
28 - Crittenden													\$ 286.16
29 - Cumberland													\$ 286.16
30 - Daviess													\$ 286.16
31 - Edmonson													\$ 286.16
32 - Elliott													
33 - Estill													\$ 286.16
34 - Fayette													\$ 286.16
35 - Fleming													\$ 286.16
36 - Floyd													\$ 286.16
37 - Franklin													\$ 286.16
38 - Fulton													\$ 286.16
39 - Gallatin													\$ 286.16
40 - Garrard													\$ 286.16
41 - Grant													\$ 286.16

Commonwealth of Kentucky
Healthcare 2004
Availability Chart

	Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	091	092	093	095	101	102	103	105	151	162	143	145	
42 - Graves													\$ 288.36
43 - Grayson													\$ 286.16
44 - Green													\$ 286.16
45 - Greenup													
46 - Hancock													\$ 286.16
47 - Hardin													\$ 286.16
48 - Harlan													\$ 288.36
49 - Harrison													\$ 286.16
50 - Hart													\$ 286.16
51 - Henderson													
52 - Henry													\$ 286.16
53 - Hickman													\$ 286.16
54 - Hopkins													\$ 286.16
55 - Jackson													\$ 288.36
56 - Jefferson													\$ 286.16
57 - Jessamine													\$ 286.16
58 - Johnson													\$ 286.16
59 - Kenton													\$ 286.16
60 - Knott													\$ 286.16
61 - Knox													\$ 286.16
62 - Larue													\$ 286.16
63 - Laurel													\$ 286.16
64 - Lawrence													
65 - Lee													\$ 286.16
66 - Leslie													\$ 286.16
67 - Letcher													\$ 286.16
68 - Lewis													\$ 286.16
69 - Lincoln													\$ 286.16
70 - Livingston													\$ 286.16
71 - Logan													\$ 286.16
72 - Lyon													\$ 286.16
73 - McCracken													\$ 286.16
74 - McCreary													\$ 286.16
75 - McLean													\$ 286.16
76 - Madison													\$ 286.16
77 - Magoffin													\$ 286.16
78 - Marion													\$ 286.16
79 - Marshall													\$ 288.36
80 - Martin													\$ 286.16
81 - Mason													\$ 286.16
82 - Meade													\$ 286.16

**Commonwealth of Kentucky
Healthcare 2004
Availability Chart**

	Bluegrass Family Health				CHA				Humana				Employer Contribution OR Lowest Cost Single Opt A Plan
	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	HMO	POS	PPO	EPO	
	091	092	093	095	101	102	103	105	151	162	143	145	
83 - Menifee													\$ 288.36
84 - Mercer													\$ 286.16
85 - Metcalfe													\$ 286.16
86 - Monroe													\$ 286.16
87 - Montgomery													\$ 286.16
88 - Morgan													\$ 312.00
89 - Muhlenburg													\$ 286.16
90 - Nelson													\$ 286.16
91 - Nicholas													\$ 286.16
92 - Ohio													\$ 286.16
93 - Oldham													\$ 286.16
94 - Owen													\$ 286.16
95 - Owsley													\$ 286.16
96 - Pendleton													\$ 286.16
97 - Perry													\$ 286.16
98 - Pike													\$ 288.36
99 - Powell													\$ 286.16
100 - Pulaski													\$ 286.16
101 - Robertson													\$ 286.16
102 - Rockcastle													\$ 288.36
103 - Rowan													\$ 312.00
104 - Russell													\$ 286.16
105 - Scott													\$ 286.16
106 - Shelby													\$ 286.16
107 - Simpson													\$ 286.16
108 - Spencer													\$ 286.16
109 - Taylor													\$ 286.16
110 - Todd													\$ 286.16
111 - Trigg													\$ 286.16
112 - Trimble													\$ 286.16
113 - Union													
114 - Warren													\$ 286.16
115 - Washington													\$ 286.16
116 - Wayne													\$ 286.16
117 - Webster													\$ 286.16
118 - Whitley													\$ 286.16
119 - Wolfe													\$ 286.16
120 - Woodford													\$ 286.16

ELIGIBILITY

What Is The Monthly Employer/Retirement Contribution?

Employer/Retirement contribution

For the 2004 plan year, the monthly employer/retirement contribution is \$234.00. However, if you are not able to purchase a Single Option A plan in the county in which you select coverage, the Commonwealth will provide a contribution equal to the lowest cost Single Option A plan available in the county in which you select your coverage.

Active Employees only

If you waive your health insurance coverage and wish to direct the employer contribution to a Health Care Flexible Spending Account, the maximum employer contribution will be \$234 (the employer contribution). If you are able to purchase a plan for less than \$234, you will receive the monthly employer contribution of \$234 toward your Public Employee Health Insurance plan. Any excess funds may be available for a Health Care Flexible Spending Account, if you are eligible and you complete the appropriate application. If the employer contribution for the lowest cost Single Option A plan in your county is higher than \$234 and you waive coverage, you will only receive the \$234 – not the amount contributed to a health insurance plan (i.e. – you live in Franklin County and you elected to have a single health insurance plan, the Commonwealth would contribute \$286.16 toward that single plan. However, if you waive coverage, you will receive \$234).

Payment options

State employees may choose to have their portion of the health insurance premium split between the two paychecks received each month. This means one-half of the employee's share of the premium will be deducted from the check received on the 15th of the month and the other half will be deducted from the check received on the 30th of the month. Premiums are paid one month in advance. For example: Your first half of the January 2004 premium will be deducted from the check you receive on December 15, 2003. You may choose the twice-monthly option by marking the "Twice Monthly" box on the application in Section II, # 5. If no option is marked, you will be defaulted to twice monthly.

The default payment option is twice monthly. If you want to pay monthly, you must indicate so on your application.

Paying your premiums with tax free dollars (Premium Conversion)

State Employees – The Premium Conversion program allows you to pay your health insurance premiums with pre-tax dollars. This saves you money. You are automatically enrolled unless you sign a cancellation form. Anyone who has already cancelled out of this program and now wishes to participate MUST complete an enrollment form. Contact your Health Insurance Coordinator for a re-enrollment form.

New Employee Information

As a new employee, what must I do?

New employees of:

- State Agencies
- Boards of Education
- Health Departments
- KCTCS

You have 30 days from the date you are hired to:

- Enroll in a plan that is offered in the county where you live, work or, if applicable, a contiguous county (see pages 31-33); **OR**
- Waive (decline) coverage by completing Sections I, II #2 and Section VII of the health insurance application.

Applications are available from your Health Insurance Coordinator.

Members of groups other than those listed above; please see your Health Insurance Coordinator for additional information. Applications must be signed 30 days prior to the coverage effective date.

What if I do not enroll in health coverage when I am first eligible?

If you do not complete an application to select health insurance, or to waive coverage, no later than 30 days from your hire date (or appropriate deadline), **you will not have coverage for the 2004 plan year.** You will **NOT** be eligible to enroll until the next Open Enrollment Period unless you experience a Qualifying Event that would enable you to enroll.

When is my coverage effective?

For employees of:

- State Agencies
- Boards of Education
- Health Departments
- KCTCS

Coverage of a new employee will begin the first day of the second calendar month following employment. For example, if you are hired anytime during the month of January, your health insurance will be effective March 1.

Members of groups other than those listed above; please see your Health Insurance Coordinator regarding effective dates.

If I do not use my employer contribution (\$234), can I use that money in a Flexible Spending Account?

If you do not use the entire employer contribution (up to \$234) for your health insurance plan, or if you waive coverage, you may qualify for an employer contribution to a Health Care Flexible Spending Account. The money in this account may be used to pay for eligible unreimbursed medical expenses for you and your family. For more information on the Flexible Spending Account Program and to obtain an enrollment form, contact your Health Insurance Coordinator. Participation in the Flexible Spending Account program is NOT automatic. You must complete an enrollment form no later than 30 days of your employment (or appropriate deadline).

Who is Eligible to Participate in the Public Employee Health Insurance Program?

Eligible participants

Full-time employees of the following agencies are eligible to participate:

- State Agencies
- Boards of Education
- Health Departments
- KCTCS
- Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program.

Retirees, under age 65, who draw a monthly retirement check from any of the following retirement systems, are eligible to participate:

- KCTCS
- Kentucky Judicial Retirement Plan
- Kentucky Legislators Retirement Plan
- Kentucky Retirement Systems (KRS)
- Kentucky Teachers' Retirement System (KTRS)

Other eligible participants

- Eligible COBRA participants.

Employees, retirees, COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

Who can you cover under your state-sponsored health plan?

The following persons are considered dependents of an employee, retiree, or COBRA participant and are eligible for coverage under the employee's/retiree's state-sponsored health plan:

- An employee's legal spouse,
- An employee's unmarried legal child(ren) (natural, adopted, step and foster) and grandchildren (if the required notarized statement is on file) who meet the definition of dependent child as follows:
 - Up to the age of 24 if the child:
 - Lives with the employee in a parent-child relationship; and depends on the employee or employee's spouse for 50% or more of his/her support; **OR**
 - Is the subject of a court or administrative order requiring the employee or the spouse to provide health insurance for his/her child.
 - At the age of 24 or older, if the child:
 - Is dependent on the employee for support and maintenance; **AND**
 - Is incapable of self-support due to a physical or mental disability that occurred **BEFORE** the dependent's 24th birthday; **AND**
 - Is the subject of a doctor's statement (provided with the application) stating (1) that the child cannot work for a living due to the physical or mental

disability and (2) the date of onset of the illness. The carrier may verify this annually.

For divorced employees who are both eligible for the Public Employee Health Insurance Program, the children can only be covered under one state-sponsored plan

Dependent Children Turning 24

Dependent children may be covered on your health insurance up to the age of 24 (end of month in which he or she turns 24) without regard to student status. Dependent children age 24 or older must meet criteria outlined on pages 23-24 to remain eligible for health insurance. Your dependent(s) over age 24 will be removed from your plan at the end of the month in which he/she turns 24. If removing this dependent from your plan will change your level of coverage, your level of coverage will be automatically changed by the system as follows:

- A Parent Plus plan will change to Single.
- A Family Non-Cross-Reference will change to a Couple.
- A Family Cross-Reference will change to a Couple cross-reference

Can I Waive (Decline) My Health Insurance Coverage?

Yes, you have the option to waive (decline) coverage if you do not want the state-sponsored health insurance.

To waive coverage, you **MUST** complete Sections I, II #2 and VII of the health insurance application and turn it in to your Health Insurance Coordinator no later than 30 days after your employment date. If you are enrolled in a health insurance plan for 2003 and wish to waive coverage for 2004, you must complete Sections I, II #2 and VII of the health insurance application during Open Enrollment. If you have waived health insurance coverage for 2003 and wish to continue to waive coverage for 2004, you do not have to complete a waiver application.

If you waive coverage because you are covered under another group plan and that coverage terminates (a Qualifying Event), you will be allowed to sign up for one of the state-sponsored health plans that is available in the county where you live, work or, if applicable, a contiguous county (see pages 31-33). You must submit an application no later than 30 days after losing coverage. The effective date of coverage will be the first day of the first month from the signature date on the application.

Retirees should refer to the Health Insurance Enrollment Notice provided by the retirement systems for details on waivers.

If I waive coverage, what will happen to the employer contribution?

If you waive your health insurance, you may be eligible to direct the employer contribution into a Health Care Flexible Spending Account (see below). However, in order to do so, you must complete a Flexible Spending Account application.

- State agency employees may direct the employer contribution of \$234.00 to the Commonwealth Choice Health Care Spending Account.
- Board of Education employees should contact their Health Insurance Coordinator for more information about Flexible Spending Account options.
- Health Department employees should contact their Insurance Coordinator at the local Health Department about Flexible Spending Account options.
- KCTCS employees are eligible for a Flexible Spending Account Program. Contact your Health Insurance Coordinator for an enrollment form and handbook.
- Members of other groups may be eligible for a Flexible Spending Account Program. Contact your Health Insurance Coordinator.

Retirees are not eligible for participation in a Flexible Spending Account Program.

What Level of Coverage is Right for Me?

Participants in the Public Employee Health Insurance Program are eligible to enroll in the following levels of coverage:

Single – Covers the employee/retiree ONLY.

Parent Plus – Covers a married or single employee/retiree and one or more children, but does not cover the spouse (dependent information MUST be provided).

Couple – Covers an employee/retiree and his/her spouse; does not cover children (spouse information MUST be provided).

Family – Covers an employee/retiree, spouse and one or more children (dependent information must be provided).

Payment Options

Monthly – Health Insurance premium is deducted from the last paycheck of the month.

Twice Monthly – Health Insurance premium is deducted equally from both paychecks. If monthly or twice monthly is not indicated on the application, the system will default to twice monthly.

Couple Cross-Reference - If both husband and wife are eligible for the Public Employee Health Insurance Program, they may choose to have both of their employer contributions go toward a couple plan (spouse information MUST be provided).

Couples may cross-reference. However, it may be less expensive to choose two Single plans. You need to decide which is the best choice for you.

Family Cross-Reference - If both husband and wife are eligible for the Public Employee Health Insurance Program, and they also have children they wish to cover, they may choose to have both of their employer contributions go toward a family plan (dependent information MUST be provided).

The following requirements must be met in order to cross-reference:

1. Both husband and wife must be eligible for state-sponsored health insurance from one of the following groups:
 - State Agency
 - Board of Education
 - Health Department
 - KCTCS
 - Members of additional groups whose employers pay into a state-sponsored retirement system and have elected to participate in the Public Employee Health Insurance Program.
 - KCTCS Retirees under age 65.
 - Kentucky Retirement System members under age 65.
 - Kentucky Teachers' Retirement System members under age 65.
2. One application must be completed requesting either couple or family and indicate cross-reference. The two employer contributions (husband's and wife's) will be

applied toward the cost of the couple or family plan and any additional premium will be divided evenly with half coming out of each spouse's paycheck/retirement check.

3. Both must be covered by the same health insurance plan and at the same level of coverage in the same county.

NOTE: Recipients of the Judicial and Legislators Retirement Plans are NOT eligible for cross-reference.

Reminder: You may not cross-reference with yourself.

What happens if I marry during the Plan Year and want to cross-reference with my new spouse but we are enrolled in different plans?

When two employees/retirees, enrolled in different plans, marry during the plan year, one of the employees/retirees will be allowed to change to the other spouse's plan so they may cross-reference. Appropriate paperwork indicating this change **MUST** be completed no later than 30 days after the marriage. All other requirements **MUST** be met.

What happens if my spouse becomes employed with a group participating in the Public Employee Health Insurance Program during the Plan Year?

You will now be eligible to cross-reference with your spouse. Your spouse will have to choose the same plan as the current employee. Appropriate paperwork indicating this

change **MUST** be completed no later than 30 days after the employee is hired. All other requirements **MUST** be met.

What happens if my spouse's current employer begins participating in the Public Employee Health Insurance Program?

No changes will be allowed because no Qualifying Event has occurred.

Which County Can I Use to Select my Coverage?

If you are an active employee living and working in Kentucky, you may select coverage from your home county, work county or, if applicable, a contiguous county.

If you are an active employee living outside of Kentucky, but working in Kentucky, you must choose a carrier that is available in the Kentucky county where you work.

If you are a retiree you should refer to your respective Retirement System section in this Handbook for information on plans available to you.

County of residence – You may select your health insurance from any carrier available in the county in which you live (see the Availability Chart on pages 20-22).

County of employment – If your county of employment is different from your county of residence, you also have the option of selecting your health insurance from any carrier available in the county in which you work (see the Availability Chart on page 22-22).

Contiguous County – Legislation was passed during the 2003 Legislative Session amending the options for selecting health insurance coverage. Please read the following section carefully as it does not apply to all counties in the Commonwealth. KRS 18A.225 has been amended as follows:

If a state employee's residence and place of employment are each located in counties in which the hospitals do

not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

A contiguous county is a county in Kentucky that shares any portion of its border with another county within the Commonwealth of Kentucky.

What are my options if I live and work in counties that have a hospital that does not provide the services outlined in KRS 18A.225 (contiguous county)?

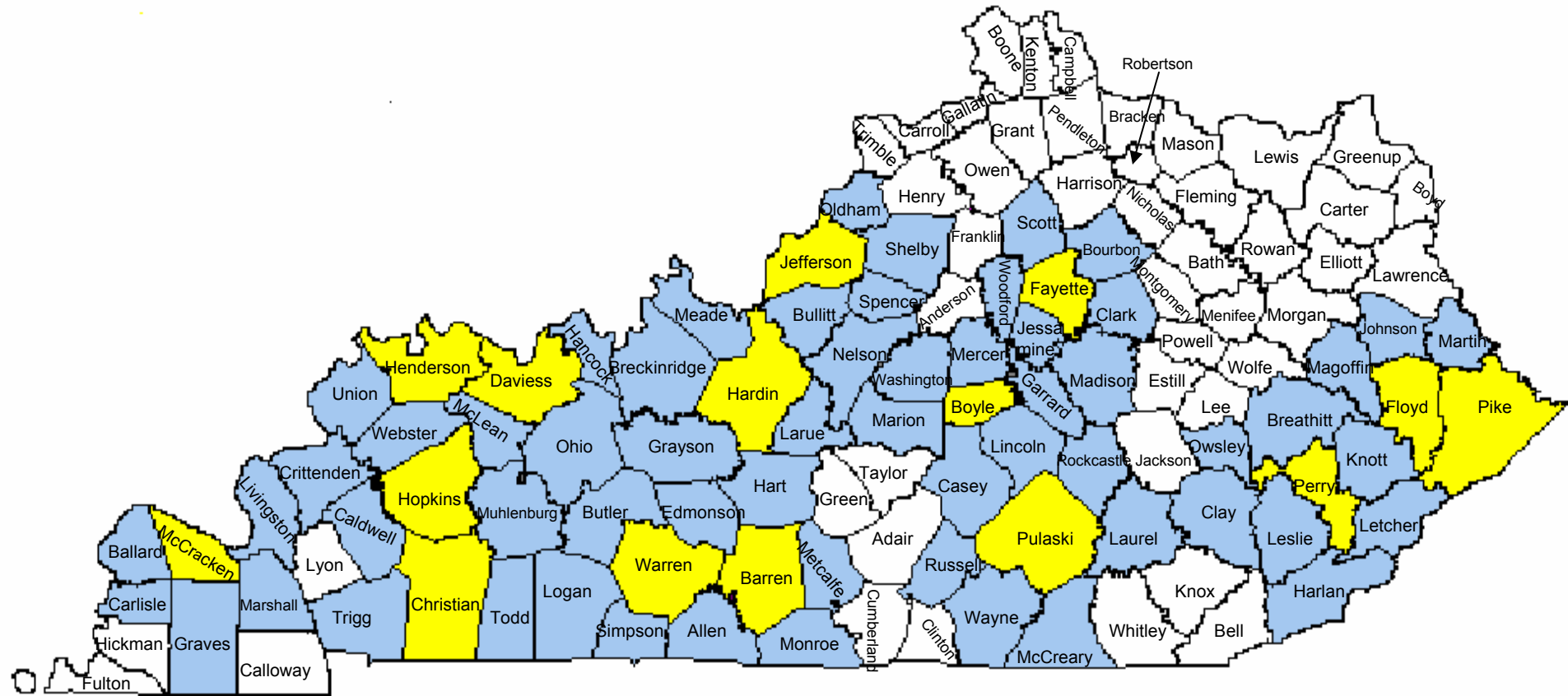
If your place of residence and place of employment are each located in one of the counties highlighted in blue on the map on page 33, you may select coverage in your county of residence, county of employment or the county highlighted in yellow that is contiguous to your county of residence. For example, if you live in Laurel County and work in Clay County, you may select your coverage from the plans offered in Laurel County, Clay County or Pulaski County (which is contiguous to your home county of Laurel).

However, if you live in Laurel County and work in Jackson County, your county of selection would be Laurel and/or Jackson County.

If you are interested in choosing your coverage with a carrier in one of the counties in yellow on the Contiguous County map, you should contact that carrier to obtain provider information. If you want to make this choice, you MUST complete a new health insurance application and you MUST mark "Contiguous County" in Section 2 #1.

Note: The Contiguous County option does not impact benefits or the carrier's provider network. This is simply an additional option for selecting coverage for employees who live and work in specific counties.

Contiguous County Map



If your county of residence and county of employment are each located in one of the counties highlighted in blue, you may select coverage in your county of residence, county of employment or the county highlighted in yellow that is contiguous to your county of residence.

Qualifying Events

What if I Want to Make Changes In My Health Insurance Outside of Open Enrollment?

Except for Open Enrollment, changes cannot be made to your election unless a Qualifying Event occurs permitting such a change. Contact your Health Insurance Coordinator or OPEHI's Member Services Branch if you have questions regarding any Qualifying Event.

All changes must be processed and approved through the OPEHI's eligibility system. It is your responsibility to ensure that all documentation is received by your Insurance Coordinator. He/she will forward all documentation to the OPEHI. The OPEHI will notify the Insurance Coordinator of the effective date of the change. If the eligibility system and payroll do not match, you are still responsible for all premiums owed.

Effective Dates – Qualifying Events

All coverage changes made outside of Open Enrollment due to a Qualifying Event are effective the first day of the first month after the signature on the application, with the exception of birth, adoption and placement for adoption. Adoption and placement for adoption are effective retrospective to the date of the adoption or placement for adoption when the appropriate paperwork is submitted no later than 30 days after the event. Effective dates for newborn are effective retrospective to the date of birth if the appropriate paperwork is submitted no later than 60 days after the birth (30 days if adding additional dependents). You must contact your

Health Insurance Coordinator or the OPEHI Member Services Branch for the effective dates.

Termination Dates – Qualifying Events

Coverage of dependents that are dropped from your plan **outside** of Open Enrollment, due to loss of eligibility (age, divorce, change in dependent status) will be terminated at the end of the month of the Qualifying Event. **Other coverage terminations are effective the last day of the month in which the employee signs the appropriate documentation if the paperwork is signed within the timeframe specified.**

Qualifying Events

Remember – any request for a change to your health insurance **MUST** be made no later than 30 days after the Qualifying Event (except for adding a newborn only).

Outside of Open Enrollment, you will not be allowed to make changes unless you experience a recognized Qualifying Event (see page 38-39 for the most common Qualifying Events and what you must do in order to make a change). For a complete list of Qualifying Events, check the OPEHI website or call OPEHI's Member Services Branch.

The changes you are allowed to make will depend on the Qualifying Event you experience. You must contact your Health Insurance Coordinator or the OPEHI Member Services Branch for additional information.

To request a change in coverage, complete the appropriate document, attach appropriate documentation (see page 37 for Qualifying Events that require supporting documentation) and turn it in to your agency's Health Insurance Coordinator no later than 30 days (60 days for birth) following the Qualifying Event.

Remember, your application **MUST** be signed no later than 30 days **AFTER** the Qualifying Event (with the exception of adding a newborn only). The inability to obtain supporting documents is not a reason for an extension.

- Applications dated after the appropriate deadline will **NOT** be accepted.

- Going on Family and Medical Leave is **NOT** a Qualifying Event to change your coverage (Example: from Family to Single) outside of Open Enrollment. You will be responsible for the employee portion of the premium while on FMLA. Although the employer contribution will continue during this leave, the entire contract will be terminated if the employee portion is not submitted to the Health Insurance Coordinator (i.e. you have a Family plan and the employer contribution is paid but you fail to submit the difference in premium, your policy will be terminated effective the last day for which premium was paid in full).

You will only be allowed to change carriers outside of Open Enrollment if:

- You move to a county where your carrier is not available; or
- You marry another employee who has a different carrier, and you wish to cross-reference. Refer to pages 29-30 for requirements.

If you are cross-referenced with your spouse and either of you experience a Qualifying Event that will affect your insurance coverage, you must complete the appropriate documentation no later than 30 days and turn it into your agency's Health Insurance Coordinator. (Example: the couple gets divorced, one or both reduces work hours, one or both goes on leave without pay, dependents are added or dropped from the plan, etc).

If I get married, when will my spouse (and any eligible dependents) be added?

Coverage on your spouse (and any eligible dependents) added to your plan outside of Open Enrollment due to marriage will begin on the first day of the first month following the date the application is signed. The appropriate documentation must be signed no later than 30 days after the marriage or the spouse (and any eligible dependents) cannot be added until the next Open Enrollment Period.

Supporting Documents needed for Qualifying Events

Divorce/Legal Separation/Annulment

If you are dropping your spouse from the plan you must provide a copy of a filed decree signed by a judge and date-stamped “filed”.

If you are enrolling because a divorce, legal separation or annulment has caused loss of other coverage you must provide a copy of the filed decree and proof that you were covered under your spouse’s plan and you are no longer eligible (example – HIPAA certificate or letter from spouse’s employer identifying date of insurance termination and persons who were covered by the policy).

Adoption/Placement for Adoption

If you are adding a dependent child as a result of an adoption or placement for adoption, you must provide a copy of one of the following:

- papers from the Cabinet for Families and Children,

- signed and date-stamped “filed” papers from the court;
- letter from the adoption agency on letterhead;
- legal document from a U.S. Court; OR
- official document translated into English.

Judgment, decree or administrative order relating to health coverage for your child

If you are making a change in your health insurance as a result of a judgment, decree or administrative order requiring you to provide coverage for your child, you must provide a copy of a filed and dated court decree; agency administrative order; or National Medical Support Notice.

Employee, spouse or dependent enrolled in Employer’s health plan becomes entitled to Medicare or Medicaid

A copy of the card AND initial eligibility letter from the Medicaid/Medicare Office.

Loss of other group health insurance coverage that entitles employee or family member to be enrolled in accordance with HIPAA

If you are making a change due to a HIPAA Special Enrollment Right, you must provide a copy of the HIPAA certificate from prior carrier; letter from employer/previous employer identifying date of insurance termination and persons who were covered by policy or termination letter from government agency under whom previous coverage was held.

Qualifying Events

See page 37 for a list of supporting documents that are required for certain Qualifying Events

Qualifying Event	What Can I do?	How do I make the change?
Marriage	Within 30 days AFTER the marriage:	
	Enroll	Complete application if currently waiving
	Add spouse and dependents	Complete Add Form
	Term/drop dependents if person becomes covered under spouse's plan	Complete Drop Form
Divorce, legal separation, annulment	Within 30 days AFTER the divorce, legal separation or annulment:	
	Enroll if event causes loss of coverage under spouses plan	Complete application if currently waiving and submit supporting documentation
	Add dependents if event causes loss of coverage under spouse's plan	Complete Add Form and submit appropriate supporting documentation
	Drop spouse and family members added to former spouse's plan	Complete Drop Form and submit appropriate supporting documentation
Spouse's death	Within 30 days AFTER the spouse's death:	
	Enroll	Complete application if currently waiving
	Add dependents if event causes loss of coverage under spouse's plan	Complete Add Form
	Drop Spouse	Complete Drop Form
Birth (adding newborn only)	Within 60 days AFTER the birth:	
	Add newborn	Complete Add Form
Birth (adding newborn only)	After 60 days and up to 120 days AFTER the birth:	
	Add newborn	Complete Add Form

Qualifying Event	What Can I do?	How do I make the change?
Birth (adding newborn as well as other dependents), adoption or placement for adoption	Within 30 days AFTER the Qualifying Event (birth, adoption or placement for adoption):	
Number of employee's eligible dependents decreases (by death or child becomes ineligible)	Within 30 days AFTER event:	
	Drop affected dependent	Complete Drop Form
Spouse or dependent terminates employment and loses coverage	Within 30 days AFTER the coverage termination date:	
	Enroll if event causes loss of coverage	Complete application if currently waiving
	Add spouse and/or dependents if event causes loss of coverage	Complete Add Form
Spouse or dependent begins employment and gains coverage	Within 30 days AFTER the date coverage begins:	
	Term and Waive Coverage	Complete application to waive
	Drop spouse and dependents if event affects eligibility for coverage	Complete Drop Form

COBRA

COBRA Rights

If you and/or your dependent(s) lose your group health insurance coverage due to any of the reasons listed, you (or they) have the right to continue coverage at your (or their) own expense under COBRA. **Both you and your spouse should take the time to read this section carefully.**

Qualifying Events that entitle you to COBRA coverage	Length of Coverage
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of hours worked by the employee (Employee and covered dependents)	18 Months
Death of a covered employee (Surviving spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee* (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare* (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the terms of the Plan *(e.g., reaches age limit, marries or otherwise loses dependent status)	36 Months
Persons considered to have total disability, according to the Social Security Administration	29 Months

**Employee's Responsibility* - You must notify your agency's Health Insurance Coordinator within 60 days when one of these COBRA Qualifying Events occurs, or you may jeopardize your COBRA rights.

What is COBRA?

In 1986, a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted. It requires that most employers, sponsoring group health plans, offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This section is intended to inform you of your rights and obligations under the COBRA provisions of the law.

When you are hired and become eligible for health insurance under the Commonwealth of Kentucky's Public Employee Health Insurance Program, your insurance coordinator is required to issue to you and your spouse a **"General Notice of Right to Continue Group Health Insurance Coverage"**. Notice to your spouse is deemed notice to all dependents covered by the plan. This notice advises you and your spouse that you have a right to choose continuation coverage if you lose your group health insurance coverage because of a reduction in your hours of employment or the termination of your

employment. In addition, the spouse and/or dependent child of an employee, covered by the Plan, has the right to choose continuation coverage if group health insurance coverage under the Plan is terminated for *any* of the following reasons:

- (1) death of your spouse/employee;
- (2) termination of your spouse's/employee's employment (for reasons other than gross misconduct) or a reduction in your spouse's/employee's hours of employment;
- (3) divorce or legal separation from your spouse;
- (4) your spouse becomes entitled to Medicare or
- (5) dependent child ceases to be eligible under the spouse/employee Plan. *(e.g., reaches age limit, marries or otherwise loses dependent status)

In many instances, this notice will be handed to the employee at the commencement of his/her employment. It will be addressed to the employee and his/her spouse. **The employee's spouse has a right to see the notice, and the employee must share the notice with his/her spouse.**

Definition of Qualified Beneficiary – A qualified beneficiary is an individual covered by a group health plan on the day before a qualifying event. This is usually an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered

employee during the period of COBRA coverage is considered a qualified beneficiary.

Electing COBRA – A qualified beneficiary should notify his/her insurance coordinator if a qualifying event occurs. The insurance coordinator will then send a qualifying event notification and an election form to employees and/or their covered dependents that are entitled to COBRA coverage. ***Please be advised that it is your responsibility to inform your insurance coordinator of any address change for you, your spouse, or your dependents so that COBRA information can be mailed to the current address.***

Each qualified beneficiary has the right to elect COBRA continuation coverage. If a family is covered under the plan, each family member has the right to choose to elect COBRA coverage or not. So if an employee, spouse and dependents experience a qualifying event that allows them to elect COBRA coverage, the employee may choose to elect COBRA coverage. The spouse is in no way bound by the employee's election. The spouse may or may not elect COBRA coverage. Each individual has a separate right to elect COBRA coverage.

If COBRA is elected, the COBRA letter, election form, and a newly completed health insurance application must be submitted to the insurance coordinator within 60 days of notification or of the date of the qualifying event, whichever is later.

Premiums –The initial premium payment, which must cover all

payments back to the date of the qualifying event, must be submitted to the insurance coordinator within 45 days of the qualified beneficiary's COBRA elections. Subsequent payments should be mailed directly to the insurance carrier. Under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of 30 days for payment of the regularly scheduled premium. This means that if payment is received after 30 days from the due date, you will lose your COBRA continuation coverage.

Your Responsibilities – Under the law, you and your family member(s) have the responsibility to report certain qualifying events to your insurance coordinator. These qualifying events are marked with an asterisk on the table in this section. You should notify your insurance coordinator of a qualifying event as soon as possible. You must notify your agency's health insurance coordinator within 60 days of the date in which the COBRA qualifying event occurs. A failure to notify will likely result in the loss of your COBRA rights.

When your insurance coordinator is notified that one of these events has happened, your insurance coordinator will, in turn, notify you of your right to choose COBRA continuation coverage. You will have 60 days from the date of the qualifying event or the date of notice, whichever is later, to elect COBRA continuation coverage. If you do not make a timely election of COBRA continuation coverage, your group health insurance coverage under the Plan will end.

If you have any questions about COBRA, please contact your insurance

coordinator. Also, if you have changed your marital status, or you or your spouse has changed his/her address, please notify your insurance coordinator.

Duration of COBRA Coverage – If you choose continuation coverage, the Commonwealth is required to provide coverage identical to that provided under the Plan. A change in the plan for active employees will also apply to qualified beneficiaries. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months for most of the qualifying events listed in this section. If the qualifying event is either termination of employment or a reduction in hours worked by the employee, the required continuation coverage period is 18 months. The 18 months may be extended to 36 months if another qualifying event (such as death, divorce, legal separation, or Medicare entitlement) occurs during the original 18-month period. In no event will continuation coverage last beyond 36 months from the date of the original qualifying event that made a qualified beneficiary eligible to elect continuation coverage. At the end of the 18-month, 29-month, or 36-month continuation coverage period, qualified beneficiaries will be allowed to enroll in an individual conversion health insurance plan provided under the terms of the Plan.

The law provides that **your continuation coverage may be terminated** for *any* of the following reasons:

- (1) the Commonwealth no longer provides group health insurance coverage to any of its employees;

- (2) the required premium for your temporary continuation coverage is not paid on time;
- (3) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have;
- (4) after the date that temporary continuation coverage is elected, the qualified beneficiary becomes entitled to Medicare; or
- (5) a qualified beneficiary extends coverage for up to 29 months due to disability, and there has been a final determination that the individual is no longer disabled.

Becoming covered under another group health plan does not automatically cause your COBRA coverage to be terminated. There may be circumstances in which you are entitled to continue your COBRA coverage. Sometimes, the new group health plan will contain a preexisting condition limitation that prevents you from being eligible to participate in the plan immediately. In that case, your COBRA coverage cannot be terminated until the exclusionary period is completed. HIPAA limits the extent to which group health plans can utilize preexisting condition exclusions. So if a group health plan is unable to apply a preexisting condition exclusionary period due to HIPAA, then your COBRA coverage may be terminated.

Open Enrollment – COBRA members are eligible for Open Enrollment. The insurance carrier will send Open Enrollment information and an

application to all COBRA members. Dependents dropped from your plan during Open Enrollment are NOT eligible for COBRA continuation coverage unless the removal is due to a qualifying event (make sure your health insurance coordinator knows that the change is related to a qualifying event instead of an Open Enrollment change). Only participants, who are dropped from your plan due to a COBRA qualifying event, will be offered COBRA. It is your responsibility to advise your company, once you are on COBRA, of any changes in your address.

Proof of Prior Health

Coverage/Preexisting Conditions –

One of the primary reasons people elect COBRA continuation coverage is to avoid breaks in coverage. A 63-day break in coverage may subject participants to a preexisting condition exclusion from future group health plans. You can receive a reduction or elimination of these exclusionary periods, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your insurance carrier when you lose coverage under your plan, you become entitled to elect COBRA continuation coverage, your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your new plan's enrollment date.

Employees with Disabilities –

Qualified beneficiaries who wish to take advantage of the 11-month disability

extension must notify the carrier of the disabled qualified beneficiary's Social Security Administration disability determination. The notice must be provided within 60 days of a disability determination and prior to expiration of the initial 18-month period of COBRA coverage. The 11-month disability extension must be requested through the carrier.

PLAN OPTIONS

Important Information Regarding YOUR Benefits

Which Option is Best For You?

There's no easy answer to this question. However, be sure to consider the PPO since it combines the flexibility of provider choice with the added value of low in-network office visit co-payments, age-appropriate preventive care and lower premiums. While making your decision, be sure to consider your family's current and potential medical needs, how close your home is to medical facilities, your family situation, whether or not you have already established a relationship with a family physician, your need for preventive medical care and various other factors.

Provider Information

The carrier's provider directories and prescription formularies are subject to change throughout the year. Even though your physician may be participating with your carrier of choice as of January 1, that does not guarantee they will remain with the plan throughout the year. The plan you select will be the plan you will have for the entire year unless you experience a Qualifying Event (see pages 35-39) that would allow you to make a change. **Providers may discontinue participation with carriers at any time during the year. This is not a Qualifying Event to allow you to change plans.**

Provider directories are also available on the carrier's respective websites (see page 86 for telephone numbers and website addresses). If you do not have Internet access, you may call the

carrier's customer service numbers for any updates.

Do not assume you have access to ALL Primary Care Physicians (PCPs), specialists and hospitals listed in your carrier's Provider Directory. You must direct questions regarding physician and provider availability to your carrier.

Balance Billing

If you are enrolled in a POS or PPO plan and you use out-of-network providers, you may be "balance billed" for any amount not paid for by your insurance carrier. This means the provider (doctor, hospital or other medical providers) will bill you for the amount that your insurance carrier did not pay, in addition to your co-payment or co-insurance, after your deductible is met. Contact the carrier for additional information.

Out of Service Area Dependent Coverage

If an HMO or EPO is elected and a dependent is attending an educational facility located outside of your carrier's service area, the only out of area services covered will be for emergencies. Students will receive emergency treatment (care that a prudent lay person would reasonably have cause to believe is an emergency medical condition) at a hospital emergency room at the in-network benefits level. However, follow-up care and routine care must be received according to plan guidelines.

Pre-existing Conditions

A new employee, retiree and/or dependent that was diagnosed or treated during the six months prior to the effective date of this policy will not have coverage for those conditions for the first twelve (12) months. This twelve (12) month pre-existing period will be reduced on a month-by-month basis for any “qualifying prior coverage”, such as another employer’s health insurance plan, Medicare or Medicaid. However, an employee, retiree, or dependent that has not had coverage during the previous twelve (12) months, or has had a break in coverage of more than 63 consecutive days between the prior coverage and enrollment in this plan, will be subject to the 12 month exclusion.

Pre-existing condition limitations do not apply to pregnancy, domestic violence, genetic information in the absence of a diagnosis for such a condition, and newborn children, adopted children or children placed for adoption who are under 24 years of age, IF covered within the applicable timeframes.

Co-payments, Co-insurance and Maximums

- Deductibles and out-of-pocket limits between in-network and out-of-network services are combined.
- Emergency room co-payment (but not co-insurance) is waived if admitted to the hospital.
- Deductibles, out-of-pocket limits, and co-payments/co-insurance accumulated with one carrier will transfer when an employee must select a new carrier during a plan

year due to an appropriate Qualifying Event.

- Co-payments and co-insurance for prescription drugs do not apply to the maximum out-of-pocket limits.
- If the patient requests a brand name drug when a generic drug is prescribed, the patient pays the brand name co-pay plus the cost difference between the brand name and generic drug.

Medical Services

- Ultrasounds, in excess of one per pregnancy, require prior plan approval.
- Chiropractor visits are covered at the same benefit level as physician office visits (except annual visit limit applies to chiropractic exams). No referral is necessary.
- Ambulance coverage is limited to ground transportation unless a life threatening situation exists where air ambulance is medically necessary.
- Kidney, cornea, bone marrow, heart, liver, lung, heart/lung and pancreas transplants are covered.
- Female members may self-refer to a network OB/GYN for a well-care visit (annually), PAP test (annually) and mammograms in accordance with the age guidelines listed on page 49.

Preventive Services

All plans will provide benefits for the following preventive services (refer to the benefit grids for details on co-pays, co-insurance and deductibles):

- Annual PAP test.
- Annual routine physical.

- A mammogram covered one time between the ages 35-39 and annually for persons age 40 and older.
- Sigmoidoscopy covered at age 50 and every year thereafter.
- Cardiac risk profile blood test beginning at age 35 and every five years thereafter.
- Glucose serum test covered for all ages.
- EKG covered at age 40 and every year thereafter.
- PSA (prostate exam) covered at age 50 and every year thereafter.

REMINDERS

Become familiar with the requirements of your plan before you need to use it. Remember, if you have selected an HMO, POS or EPO, you may be required to go through your Primary Care Physician for referrals to specialists (except chiropractors) and other network providers. Please contact your carrier with questions.

Most plans require pre-certification for certain procedures such as overnight hospital stays, outpatient or elective surgery, diagnostic procedures, home health care services, etc. It is the responsibility of the patient to ensure that all pre-certification is taken care of prior to receiving services. Check with your health care provider to make sure the services have been pre-authorized.

Many prescription drugs require prior authorization. Check with your carrier to determine if your prescription requires prior authorization.

PPO – Preferred Provider Organization

Under a PPO plan:

- You pay a co-payment for doctor's office visits and prescription drugs under Option A.
- Once the annual deductible is met, you will pay only a percentage of the cost (co-insurance) for all other services.
- You may use any provider in the network.
- You have the freedom to go outside your network, however, you will pay higher deductibles and your co-insurance will increase.
 - You may also be billed for the difference between your plan's payment schedule and the non-network provider's charges (balance billing).
- Your network providers will file claims for you.

PREVENTIVE SERVICES

Preventive services are available under your PPO benefits. Please refer to the Benefit Grid for applicable co-pays, deductibles, co-insurance and annual maximums.

2004 Medical Plan Options

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: \$250 Family: \$500	Single: \$500 Family: \$1,000	Single: \$500 Family: \$1,000	Single: \$1,000 Family: \$2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: \$1,250 Family: \$2,500	Single: \$2,500 Family: \$5,000	Single: \$2,000 Family: \$4,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	\$10 co-pay (per visit) \$400 maximum benefit per year	40% co-ins*	\$20 co-pay (per visit) \$300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Emergency Services				
	Hospital Emergency Room – \$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay plus 20% co-ins	\$50 co-pay plus 40% co-ins	\$50 co-pay plus 25% co-ins	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	\$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Services-\$500 monthly benefit for children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-ins*	40% co-ins* 50% co-ins*	25% co-ins* 50% co-ins*	50% co-ins* 50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.

Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

Prior approval may be required for some services. Please contact your Carrier.

HMO – Health Maintenance Organization

The following requirements must be met under the HMO coverage:

- You **MUST** select a primary care physician from the plan's network of participating providers. Your primary care physician will manage your care and coordinate your referrals to network specialists and hospitals when necessary. With the exception of true emergencies, only care received through this network process will be considered a covered benefit.
- You may be required to obtain a referral to see a specialist (any doctor other than your primary care physician, gynecologist, or a chiropractor). You must consult with your selected carrier to confirm if a referral is required.
- Your costs are generally limited to a co-payment for routine doctor's office visits and most other medical services when using participating providers.
- You will not have to meet an annual deductible.
- Your network providers will file claims for you.

PREVENTIVE SERVICES

Preventive services are available under your HMO benefits. Please refer to the Benefit Grid for applicable co-pays.

2004 Medical Plan Options

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$1,500 Family: \$3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$100 co-pay	\$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well child care, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay	\$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay	\$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay	\$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$50 co-pay	\$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	\$20 co-pay	\$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	\$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	\$10 generic \$15 brand \$30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary	\$20 generic \$30 brand \$60 non-formulary
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay	\$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-\$500 monthly benefit for children 2 through 21 years of age		
	• Rehabilitative and Therapeutic care	\$10 co-pay	\$20 co-pay
	• Respite Care	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	\$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	\$100 co-pay	\$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

POS – Point of Service

The In-network benefits of a POS are similar to an HMO in that:

- You **MUST** select a primary care physician to manage your care and coordinate your referrals to network specialists and hospitals, if your plan so requires – check with your carrier.
- You are required to obtain a referral to see a specialist (any doctor other than your primary care physician or a chiropractor).
- Female members may self-refer to a network OB/GYN annually for a well-care visit and PAP test.
- You only pay a co-payment for most services when using a network provider.
- Your network providers will file claims for you.
- There are no deductibles to meet when using network providers.
- A POS also gives you the option to go outside the network of participating providers for services. If you do choose to go outside the network, the plan will pay for the services at a reduced rate after deductibles are applied. You may also be billed for the difference between your plan's payment schedule and the non-network provider's charges (balance billing).

PREVENTIVE SERVICES

Preventive services are available under your POS benefits. Please refer to the Benefit Grid for applicable co-pays, co-insurance and deductibles.

2004 Medical Plan Options

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: \$500 Family: \$1,000	None	Single: \$1,000 Family: \$2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$1,000 Family: \$2,000	Single: \$2,500 Family: \$5,000	Single: \$1,500 Family: \$3,000	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	\$100 co-pay (per admission)	40% co-ins*	\$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$50 co-pay (per visit)	40% co-ins*	\$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – \$50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	\$50 co-pay (per visit)	\$50 co-pay plus 40% co-ins	\$50 co-pay (per visit)	\$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	\$20 co-pay (per visit)	40% co-ins*	\$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	\$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	\$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$10 generic \$15 brand \$30 non-formulary	40% co-ins*	\$10 generic \$15 brand \$30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$20 generic \$30 brand \$60 non-formulary		\$20 generic \$30 brand \$60 non-formulary	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	\$10 co-pay (per visit)	40% co-ins*	\$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-\$500 monthly benefit for children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	\$10 co-pay 50% co-insurance	40% co-ins* 50% co-insurance*	\$20 co-pay 50% co-insurance	50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	\$10 co-pay	40% co-ins*	\$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	\$100 co-pay	40% co-ins*	\$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

EPO – Exclusive Provider Organization

- EPO is designed to be more affordable by offering limited benefits (catastrophic coverage) with higher deductibles and co-pays.
- ALL services **MUST** be provided in-network.
- Preventive tests and immunizations **MUST** be provided by participating health departments if the health departments contract with your carrier. If the carrier does not have a contract with the appropriate health department, you may obtain services at your designated primary care physician or other participating provider, as permitted by the rules of your carrier.
- You must select a primary care physician – please confirm with your carrier.

PREVENTIVE SERVICES

Preventive services for the EPO may be mandated through county Health Departments. Contact your health insurance carrier to determine if services need to be obtained through the Health Department.

2004 Medical Plan Options

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: \$4,000 Family: \$8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	\$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	\$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	\$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	\$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	\$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	\$50 co-pay (per visit)
	Ambulance (per use)	\$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	\$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	\$25 generic \$35 brand \$50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	\$50 generic \$70 brand \$100 non-formulary
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, \$1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-\$500 monthly benefit for children 2 through 21 years of age	
	<ul style="list-style-type: none"> Rehabilitative and Therapeutic care Respite Care 	\$25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	\$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	\$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	\$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	\$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	\$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

What About Prescription Drug Coverage?

Mail Order Prescription Drug

Each plan offered by the Public Employee Health Insurance Program includes an optional Mail Order Prescription Drug benefit that provides for a 3-month or 90-day supply of maintenance drugs for the cost of a 2-month or 60-day supply. The only maintenance drugs that may be dispensed through mail order are those for which there have been at least 3 claims for a 30-day supply within the last 4 months, or at least 1 claim for a 90-day supply in the last 6 months, including a mail order prescription. Further, the drug must be required for maintenance therapy as determined by the prescribing provider. The prescription must be written for a 90-day supply with refills, if necessary.

The mail order option shall not permit the dispensing of a controlled substance classified as Schedule II.

A health insurance carrier shall not discriminate against any retail pharmacy located within the geographic coverage area of the health benefit plan and that meets the terms and conditions for participation established by the insurer, including price, dispensing fee, and co-pay requirements of a mail order option. The retail pharmacy shall not be required to dispense by mail.

Prescription Drug Coverage

- If the patient requests a brand name drug when a generic drug is prescribed, the patient pays the brand name co-pay plus the cost difference

between the brand name and generic drug.

- The co-payment for prescription drugs purchased at a retail pharmacy applies to each one-month or 30-day supply.
- Each health insurance carrier has an established list of preferred drugs (formulary). This formulary is subject to change during the plan year. Decisions for inclusion on the preferred list are based on the drug's safety, effectiveness and cost. Some drugs require prior authorization before the carrier will cover any of the cost. **Remember, this preferred drug list varies by carrier and is subject to change during the year.**
- The prescription drug benefit offered by most plans usually covers FDA approved generic drugs, as well as many brand name drugs. Usually, several "non-preferred" medications are available without prior authorization upon payment of a higher co-payment. Each plan has certain drugs that, due to the nature of the medication, require prior authorization before the plan will cover any portion of the cost. These drugs are not automatically available for payment at the higher third tier co-payment. In most instances, only physicians may request prior authorizations as they are based on your medical history. Some plans also establish drug use guidelines in an effort to promote the appropriate use of certain medications. These guidelines may require you to try a drug that has been in use for a longer

time before the plan will approve payment for a new and perhaps more expensive alternative.

- Prescription drugs for the treatment of non-covered medical services are not covered under the plan.

75 Prescription Rule

- When an employee's health insurance contract has paid 75 co-payments/co-insurances in a calendar year for prescription drugs – excluding mail order prescriptions, additional co-payments/co-insurance for retail prescription drugs received during that plan year by any person covered under that contract will be reduced to the amounts provided on the following chart rather than the amounts on the benefit grids on pages 50-57. This reduction may be approved at the point of sale or through reimbursement to the covered person no later than thirty-one (31) days after the end of the plan year. Check with your carrier for the individual reimbursement policies.

PRESCRIPTION DRUG CO-PAYMENTS/CO-INSURANCE BEGINNING WITH THE 76ST COPAYMENT APPLICABLE TO A CONTRACT IN A CALENDAR YEAR

HMO	In-Network		Out-of-Network	
	Up to 75	76+	Up to 75	76+
Generic	\$10	\$5	N/A	N/A
Brand	\$15	\$10		
Non-formulary	\$30	\$20		

POS	Option A			
	In-Network		Out-of-Network	
	Up to 75	76+	Up to 75	76+
Generic	\$10	\$5	40%	30% co-ins.
Brand	\$15	\$10		
Non-Formulary	\$30	\$20		

POS	Option B			
	In-Network		Out-of-Network	
	Up to 75	76+	Up to 75	76+
Generic	\$10	\$5	50%	40% co-ins.
Brand	\$15	\$10		
Non-Formulary	\$30	\$20		

PPO	Option A			
	In-Network		Out-of-Network	
	Up to 75	76+	Up to 75	76+
Generic	\$10	\$5	40%	30%
Brand	\$15	\$10		co-ins.
Non-Formulary	\$30	\$20		

PPO	Option B			
	In-Network		Out-of-Network	
	Up to 75	76+	Up to 75	76+
Generic	\$10	\$5	50%	40%
Brand	\$15	\$10		co-ins.
Non-Formulary	\$30	\$20		

EPO	In-Network		Out-of-Network
	Up to 75	76+	
Generic	\$25	\$15	N/A
Brand	\$35	\$25	
Non-Formulary	\$50	\$40	

Exclusion of Benefits

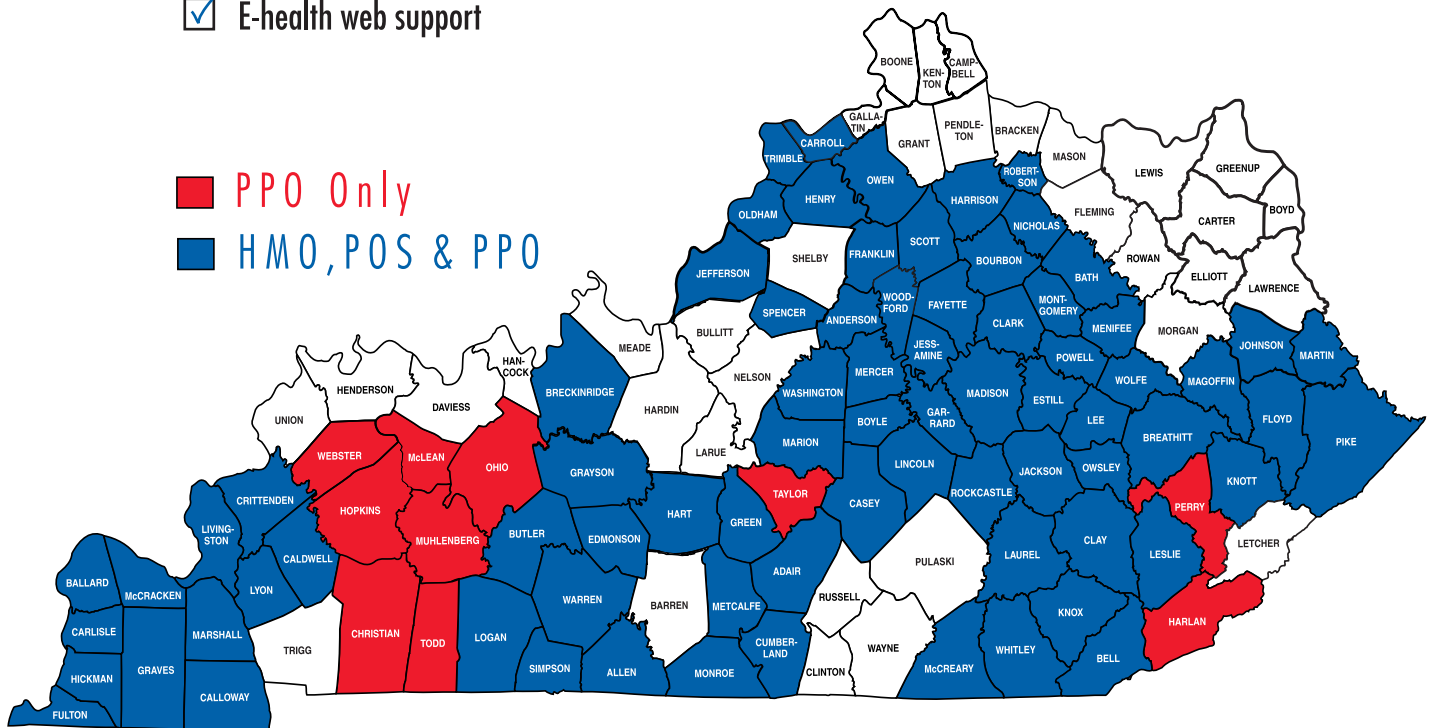
There are some medical expenses the Plan does not cover. They include, but are not limited to, services or supplies that are not medically necessary and routine procedures not related to the treatment of injury or illness. Your Certificate of Coverage will list all of the exclusions and will provide additional details on the exclusions listed below. Some of the expenses that are not covered are:

- Services related to a pre-existing condition in the first 12 months of coverage (the 12 months may be reduced by any creditable coverage you bring to the Plan);
- Abortion;
- Acupuncture;
- Cosmetic Services;
- Custodial care, including sitters and companions;
- Dental services except as otherwise specifically provided;
- Equipment that has a non-therapeutic use (such as humidifiers, air conditioners, whirlpools, artificial hair replacement or fitness supplies);
- Experimental or Investigational Services;
- Eyeglasses, contact lenses (unless medically necessary after cataract surgery) and routine eye examinations;
- Infertility;
- Over-the-counter contraceptive devices;
- Over-the-counter drugs;
- Refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea;
- Services performed by the insured or a relative;
- Services for job, occupational or school placement or for educational purposes;
- Services, supplies, drugs or other care not medically necessary for the diagnosis or treatment of a physical or mental illness, injury or symptomatic complaint;
- Services or supplies payable by Workers' Compensation;
- Sex Transformation/Sexual Dysfunction or inadequacies;
- Weight reduction programs or treatment for obesity (except for surgery for morbid obesity where the condition is of a life-threatening nature to the covered person).

Bluegrass Family Health

Why should you select Bluegrass Family Health as your Healthcare Plan?

- ✓ Offering Health Insurance to Commonwealth of Kentucky employees for 10 years
- ✓ Kentucky based company
- ✓ Not-for-profit health plan
- ✓ Competitive rates
- ✓ Survey results show that Bluegrass Family Health provides exceptional Customer Service
- ✓ Comprehensive provider network and service area
- ✓ Bluegrass Family Health now serves over 124,000 members, and we are continuing to grow.
- ✓ E-health web support



Visit Our Website at
www.bgfh.com

Bluegrass Family Health is committed to providing you and your family a comprehensive network of physicians and medical providers, as well as exceptional customer service. In making your coverage selection for Plan Year 2004, be sure to consider our competitively-priced PPO option. This plan may offer the benefits your family needs and still fit comfortably into the family budget.

We hope you will consider Bluegrass Family Health as your health plan choice for the year 2004.

Our Customer Service Representatives are waiting to answer your questions:
(859) 269-4475 or (800) 787-2680

60 Counties Count on CHA Health

Shouldn't you? CHA Health is the one resource for healthcare services that gives you peace-of-mind.

With our **Assist America**® product, you can travel worry free. It gives you access to emergency medical services when you're more than 100 miles away from home.

With our online service, **myCHAIinfo**, you have 24-hour access to your information, including the status of your claims and provider directory.

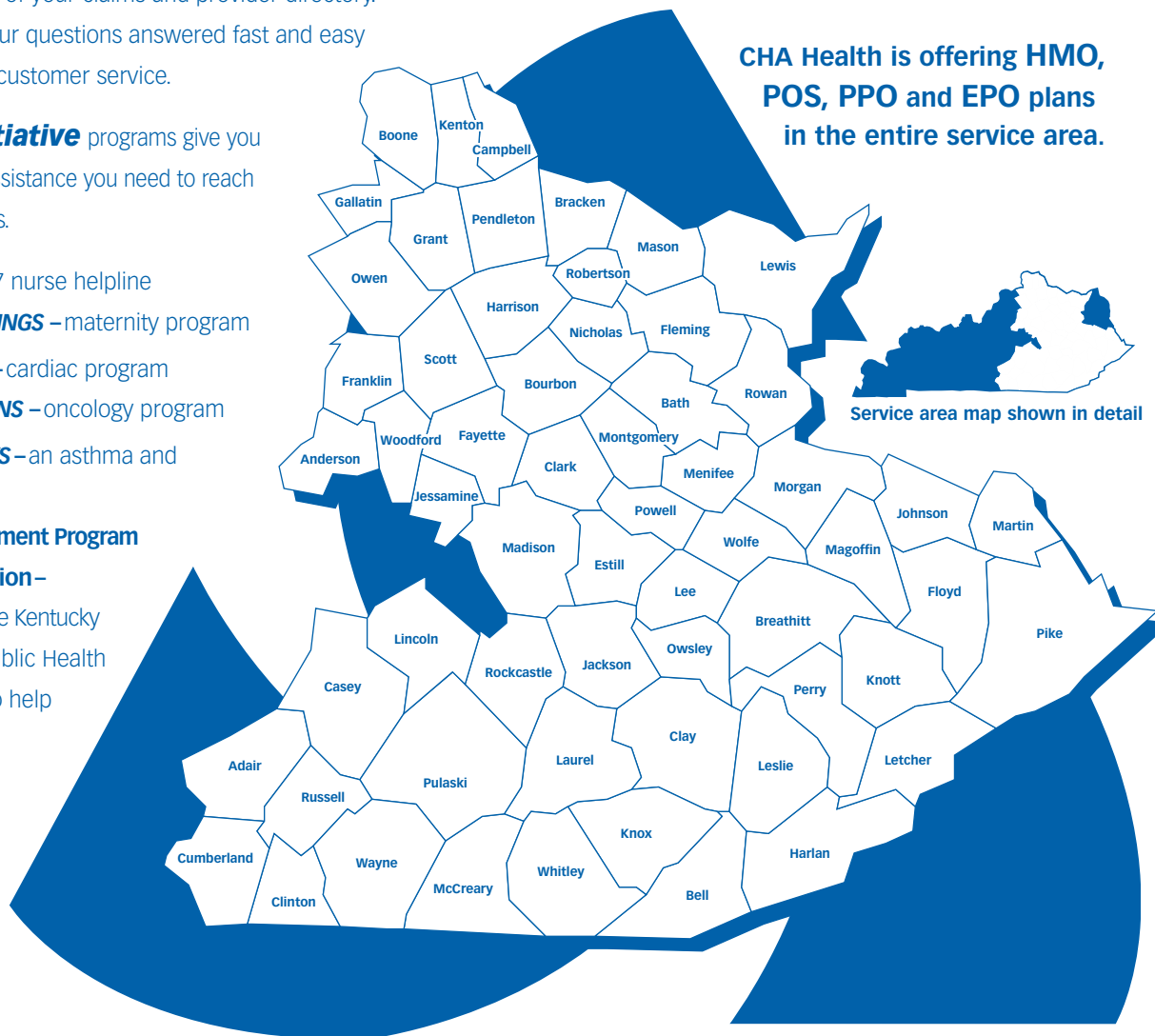
You also can get your questions answered fast and easy through our online customer service.

Our **Healthy Initiative** programs give you the resources and assistance you need to reach your healthcare goals.

- **NURSE411™** – 24/7 nurse helpline
- **HEALTHY BEGINNINGS** – maternity program
- **HEALTHY HEART** – cardiac program
- **HEALTHY HORIZONS** – oncology program
- **HEALTHY AIRWAYS** – an asthma and COPD program
- **Migraine Management Program**
- **Smoking Cessation** –
CHA Health and the Kentucky Department for Public Health have partnered to help you quit smoking.

*Good Ideas.
Good Health.
Good Choice.*

CHA Health is offering HMO, POS, PPO and EPO plans in the entire service area.



For more information call toll-free at 800-840-3885.

We're there for you when you need us.
Humana offers you health and wellness information and the choice to access the information anytime, day or night, 24-hours-a-day, seven days a week – at a time that's right for you.

Visit www.humana.com to check out all of the services we offer to provide you with vital health information you need to manage both your health and your health plan.

- **Physician Finder *Plus*** – online provider search
- **MyHumana** – personal health page
- **Maximize your Benefit** – prescription drug messaging system

- *You get a total benefit package*
- *A full range of coverage and services*
- *All at a cost you can afford*



HUMANA®
Guidance when you need it most

GENERAL INFORMATION

What is the Health Insurance Portability and Accountability Act (HIPAA)?

HIPAA

HIPAA stands for the Health Insurance Portability and Accountability Act. This law, passed by Congress in 1996, helps to protect an employee's rights to health coverage during events such as changing or losing jobs, pregnancy, moving or divorce. It also provides rights and protections for employers when obtaining and renewing health coverage for their employees. HIPAA is **NOT** an insurance policy.

HIPAA and the OPEHI

The HIPAA Privacy Rules became effective April 14, 2003. The Privacy Rules were issued to provide protection against the unauthorized use and disclosure of an individual's Protected Health Information (PHI). The OPEHI is adhering to these rules in order to protect the confidentiality of our members. PHI is defined as information that can be identified as belonging to a specific individual. This information can be transmitted or maintained in many ways such as, but not limited to: mail, fax, copier, telephone, email or paper mediums.

Health Insurance and Flexible Spending Account information maintained by the OPEHI will only be disclosed to the member. The OPEHI will only provide information pertaining to eligibility, enrollment, disenrollment and Qualifying Events. Information pertaining to payment of claims and benefits covered under the health plan must be directed to the member's health insurance carrier.

Beginning January 1, 2004, (new plan year) members of the Public Employee Health Insurance Program will be able to complete and sign an Authorization for Disclosure Form to allow the OPEHI to disclose information pertaining to eligibility, enrollment, disenrollment and Qualifying Events regarding a member's health plan and/or flexible spending accounts to the member's spouse or dependents. Information pertaining to payment of claims and benefits covered under the health plan must be directed to the health insurance carrier. The authorization forms will be placed on the OPEHI's website beginning with the new plan year or members can contact the OPEHI's Member Services Branch to request a copy of the form. An example of the Authorization for Disclosure Form that will be used beginning plan year 2004 is on the following page.

The member will need to contact his/her carrier for information relating to payment of claims and which benefits are covered under the member's health plan. If the member needs to have information disclosed from the carrier to someone other than him/her, the carrier may require the member to complete its company's Authorization for Disclosure Form. The Authorization for Disclosure Form completed for the OPEHI to disclose PHI will not be accepted by the carrier. The member will be required to abide by the carrier's policies and procedures concerning release of the member's PHI.

If you have any questions pertaining to HIPAA, please contact our office.

**AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION
BY OPEHI**

I, (1) Jane Doe 999 - 99 - 9999 and 01 / 01 / 2004
(Print Name of Employee) (Social Security Number) (Date of Birth)

authorize the OPEHI to provide the following specific information: (2) About my health coverage and flexible spending accounts.

to: (3) John Doe my (4) Spouse
(Name of Authorized Person to receive information) (Authorized person and/or relationship to Employee)

whose mailing address is: 111 Nothing Dr. Frankfort KY 40601 (502)555-5555
Mailing Address City State Zip code Telephone

The information will be used to: (5) Obtain information about my health plan.

Password or phrase to verify identity of the authorized person receiving information, in the event the disclosure is by phone: (6) Dog
(i.e. Smith, or Disneyworld, or Frizzel)

Hint for password or phrase: (7) Favorite Pet
(i.e. Mother's maiden name, or Favorite vacation destination, or Pet's name)

- I understand that:
- a. The information disclosed will pertain to eligibility; enrollment; disenrollment and qualifying events.
 - b. All issues concerning payment of claims and benefits covered need to be directed to the carriers, not OPEHI. Any information that is requested from the carrier may require an additional authorization form to be completed with that carrier.
 - c. I can revoke this authorization before it ends, except for information already disclosed, by writing to or by calling:
Office of Public Employee Health Insurance
200 Fair Oaks Lane, Suite 502
Frankfort, KY 40601
(502) 564-0358
 - d. There may be a reasonable, cost based fee charged by the OPEHI to process the requested information. Postage (as necessary) shall be charged.
 - f. ** The information released under this authorization may be subject to re-disclosure by the authorized person (9) below and the re-disclosure **may not** be protected under federal/state regulations.

This authorization is good until (8) 12 / 31 / 2005 or Revoked by me
Date Event

(9) Jane Doe 01 / 01 / 2004
(Signature of Employee) ** Date

111 Nothing Dr. Frankfort KY 40601
Mailing Address City State Zip code

What About Flexible Spending Accounts?

You may enroll in one or more flexible spending accounts (e.g. health and/or dependent care) offered by your employer. You may contribute specified amounts from your salary. Please contact your Health Insurance Coordinator for specific information.

The State will contribute a set amount toward your health insurance each month. If the plan you choose costs less than the employer contribution (\$234), you may qualify to have the remaining amount deposited into a Health Care Flexible Spending Account. You must complete an enrollment form for the Flexible Spending Account Program (in addition to the Health Insurance Application). For state agency employees, the Flexible Spending Account application has been combined with the health insurance application. Enrollment is not automatic and you must re-enroll each year.

- **State Agency Employees** – You are eligible for the Commonwealth Choice Flexible Spending Account Program. Contact your Health Insurance Coordinator for an enrollment form and handbook.
- **School Board Employees** – All boards may not offer this benefit. To find out if a Flexible Spending Account Program is available to you, contact the Health Insurance Coordinator at your Board of Education. Each Board of Education independently contracts for its own Flexible Spending Account Program.
- **Health Department Employees** – You are eligible for a Flexible Spending

Account Program. Contact the Health Insurance Coordinator at your local Health Department.

- **KCTCS Employees** – You are eligible for a Flexible Spending Account Program. Contact your Health Insurance Coordinator for an enrollment form and handbook.
- **Members of groups other than those listed above;** please see your Health Insurance Coordinator for information regarding Flexible Spending Accounts.

Retirees are not eligible for participation in the Flexible Spending Accounts.

Grievance and/or Appeals Procedures to the Health Insurance Carrier

Every carrier has a formal complaint and appeal process for handling member concerns for disputed claims. A complaint is an oral or written expression of dissatisfaction. An appeal is a request to change a previous decision made by a carrier. A member **MUST** exhaust his/her appeal rights under a carrier's complaint and appeal process prior to bringing any other administrative or legal action. Below are the steps of the process and directions for members to follow to resolve their issues.

Initial Complaint – a member should always contact their carrier's member services numbers first (the numbers are located on the back of your ID card). Many problems can be resolved the same day. If not, the carrier's member services will investigate and contact the member with their findings and any action taken to resolve the complaint. If a member's complaint is related to a denial of coverage or other decision by the carrier, the member may file an appeal.

How to file an Appeal – If a member's carrier denies, limits, reduces or terminates coverage for treatment, procedure, drug or device a member may appeal. To appeal, a member must send a letter within 60 days after the date they receive the denial notice. A member may also appeal if the carrier does not issue a timely decision. The deadlines are stated in the members Certificate of Coverage issued by the carrier that outlines its benefits and plan rules. The member will also need to refer to their Certificate of Coverage for

an address to mail the appeal as well as a list of information that will need to be included in the written appeal.

Internal Appeal Process – A carrier shall provide a decision to members filing an appeal within 30 days of receipt of the request for internal appeal.

Expedited Appeal Process – A member may request an expedited appeal in writing or orally and follow up in writing. The member's appeal will be expedited if they are hospitalized or in the opinion of the treating provider, review under a standard timeframe could, in the absence of immediate attention, result in placing the health of the member, or with respect to a pregnant woman, the health of the member or the unborn child in serious jeopardy or serious impairment to bodily function or serious dysfunction of a bodily organ or part. On expedited appeals, the carrier must render a decision within 3 business days of receipt of the member's request for an expedited appeal.

Grievances to the Public Employee Health Insurance Program's Grievance Committee

Any employee who is dissatisfied with a decision regarding enrollment or disenrollment (Qualifying Events) in the Public Employee Health Insurance Program may file a grievance to the Public Employee Health Insurance Program's Grievance Committee. The employee must file the grievance no later than thirty (30) calendar days of the event or notice of the decision being protested.

Grievances must be filed in writing to the Public Employee Health Insurance Program, Grievance Committee, 200 Fair Oaks Lane, Suite 502, Frankfort, KY 40601.

A grievance must include all of the following items:

- A statement specifically describing the issue(s) disputed by the employee;
- A statement of the resolution requested by the employee;
- All other relevant information; and
- Any supporting documentation.

Any grievance that does not include all necessary information will be returned to the employee without review.

A written response will be mailed to the employee and the Insurance Coordinator stating the decision of the Committee.

The Committee will not review a second request unless additional relevant facts are provided.

Terms You Need To Know

Balance Billing – If you are enrolled in a POS or PPO plan, and you use the out-of-network benefits, you may be “balance billed” for any amount not paid by the insurance carrier. This means the provider (doctor, hospital, etc.) may bill you for the amount that your insurance carrier did not pay in addition to the amount of your co-payment or co-insurance. Your carrier’s payment is made based on a fee schedule, which would normally be used in Kentucky. This payment could be less than what is usually paid to providers in the state where you live or obtain services.

Co-insurance – A percentage of the charges due to the doctor, hospital, pharmacy, or other provider. This percentage may vary based on the services provided.

Co-payment – A set amount due to the doctor, hospital, pharmacy, or other provider at the time of service (e.g., \$10.00 per office visit). This amount is not included in the deductible.

COBRA – (Consolidated Omnibus Budget Reconciliation Act of 1986) – Federal law which allows employees and their dependents to continue coverage after termination from certain employer group plans.

Deductible – Initial amount of medical or hospital expenses you must pay before a health plan starts paying benefits.

Eligible Expenses – A provider’s fee which: (A) is the provider’s usual charge for a given service under the covered

person’s plan; (B) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (C) does not exceed the fee schedule developed by the carrier. The term “eligible expense” and “reasonable and customary charge” may be interchangeable.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition: (1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency medical condition is: (1) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (2) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

Formulary – A list of FDA approved drugs selected on the basis of safety, clinical efficacy, and cost-effectiveness. An experienced committee of medical experts compiles the list for each carrier. Formularies may differ among carriers.

Generic Drugs – A drug that is equivalent to a brand name drug

produced when patent protection lapses on the brand-name drug.

In-network – Physicians, pharmacies or drug stores, hospitals and other providers who have contracted with a particular carrier to provide services for persons covered on that particular plan.

In-patient Care – Care delivered to a patient who is officially admitted and occupies a hospital bed while receiving hospital care.

Maximum out-of-pocket – Maximum dollar amount the covered person will have to pay for covered medical expenses during the plan year. It does not include balance billing or certain PPO services.

Out-of-network – Physician, pharmacies or drug stores, hospitals, and other providers who have not contracted with a particular carrier to provide services. Persons choosing a POS or PPO plan may use an out-of-network provider at an added expense.

Pre-certification – Prior approval required for non-emergency medical and surgical hospital admissions. The program determines the diagnostic need for certain surgical and diagnostic procedures and approves appropriate lengths of stay for admissions.

Primary Care Physician – A network provider who is a practitioner specializing in family practice, general practice, internal medicine, or pediatrics; who supervises, coordinates and provides initial care and basic medical services to a covered person; initiates a covered person's referral for specialist

services; and is responsible for maintaining continuity of patient care.

Qualifying Event – An event that may allow an employee/retiree to make a mid-year change in their health insurance or, in some cases, their FSA. The change must be in accordance with and consistent with the Qualifying Event.

Urgent Care – Medical care that is appropriate to the treatment of a non-life threatening illness or injury, but requires prompt medical attention.

Usual, Customary and Reasonable (UCR) – A provider's fee which: (a) is the provider's usual charge for a given service under the covered person's plan; (b) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar limited geographical area; and (c) does not exceed the fee schedule developed by the carrier.

RETIREE INFORMATION

The respective Retirement Systems provided the following Retirement information to the OPEHI. If you have questions regarding information contained in the following section, you may contact your Retirement System. Further, any information contained in the following section will not be binding in the event of inconsistency with the OPEHI's guidelines.

Important Information for RETIREES of the Following Retirement Systems:

Kentucky Community and Technical College System
Kentucky Judicial Retirement Plan
Kentucky Legislators Retirement Plan
Kentucky Retirement System
Kentucky Teachers' Retirement System

Retiree Health Insurance Annual Open Enrollment Plan Year 2004

September 15 – October 17, 2003
**(Your application must be received at the appropriate
retirement system no later than October 17, 2003)**

RETIREES LIVING OUT-OF-STATE

Retirees living out-of-state, except those living in a county bordering Kentucky, will have the opportunity to enroll in any of the POS or PPO plans offered by any of the carriers. You may have to pay out-of-network charges. Please contact each carrier for specific information.

Those enrolling in a POS or PPO should be cautioned that when you use the out-of-network providers, you may be "balance billed" for any amount not paid by the insurance carrier. This means the provider (doctor or hospital, etc.) may bill you for the amount that your insurance did not pay in addition to the amount of your co-payment or co-insurance. Your carrier's

payment is made based on a fee schedule, which would normally be used in Kentucky. The payment could be less than what is usually paid to providers in the state where you live.

Retirees Under Age 65

If you are a retiree under age 65, you may continue health insurance coverage at the group rate if you draw a monthly check from the Kentucky Community and Technical College System, Kentucky Judicial Retirement Plan, Kentucky Legislators Retirement Plan, Kentucky Retirement System or Kentucky Teachers' Retirement System.

You may choose any health carrier offered to active state employees as long as it is available in the county where you live or, if applicable, a contiguous county (refer to pages 31-33). Retirees living out-of-state, except those living in a county bordering Kentucky, will have a choice of any POS or PPO plan offered by the carriers. You may have to pay out-of-network charges. Please contact each carrier for specific information.

During Open Enrollment you may choose to change from one available carrier to another, change your level of coverage, change your option selection or waive your coverage.

For KCTCS Retirement Benefits call (859) 246-3113.

For Judicial Retirement Plan or Legislators Retirement Plan benefits call (502) 564-5310. See pages 77-78 for further information on the Judicial Retirement Plan and Legislators Retirement Plan.

For information on Kentucky Retirement Systems' insurance benefits, call 1-800-928-4646, ext. 4520 or (502) 564-4646, ext. 4520. See pages 79-83 for further information on the Kentucky Retirement Systems.

For Kentucky Teachers' Retirement System benefits call 1-800-618-1687 or (502) 848-8500. See pages 84-85 for further information on the Kentucky Teachers' Retirement System.

Limitation on Receipt of State Insurance Contribution

All KTRS retired members who waive their retirement annuity or are re-employed and eligible for medical coverage through the Public Employee Health Insurance Program, are required to WAIVE health insurance coverage through the Kentucky Teachers' Retirement System.

Employees who retire and return to work in a full-time status with an agency that participates in the Public Employee Health Insurance Program will need to choose whether to be covered through the retirement system or their active employment. These employees will also need to complete an application declining coverage at one place or the other at the time they return to work in a full-time status with an agency that participates in the Public Employee Health Insurance Program. Remember that the employee/retiree is entitled to only one state contribution and cannot elect health insurance and an employer-sponsored flexible spending account.

Medicare and the Public Employee Health Insurance Program

Questions regarding coordination of benefits with Medicare should be directed to Medicare. Eligibility questions regarding Medicare and the Public Employee Health Insurance Program should be directed to the appropriate retirement system.

Information for RETIREES of the Kentucky Judicial Retirement Plan (JRP) and Kentucky Legislators Retirement Plan (LRP)

Retirees Who Returns to Work

Retirees of JRP or LRP who return to work with an agency that participates in the Public Employee Health Insurance Program may not cross-reference with themselves or elect coverage through the retirement system and put their employer contribution into a flexible spending account. Retirees who wish to participate in the Public Employee Health Insurance Program must choose to participate through the retirement system or the employer. Retirees must also waive coverage with either the retirement system or the employer, whichever is not selected to provide their health care coverage at the time they return to work in a full-time status with an agency that participates in the Public Employee Health Insurance Program.

Judicial Retirement Plan and Kentucky Legislators Retirement Plan Benefits

If you are a retiree or a beneficiary receiving retirement benefits from JRP or LRP and are under age 65, you are eligible to apply for the health insurance coverage described in this handbook. The insurance carriers and plans offered in this handbook are the same for retirees and state employees. However, the administrative procedures for retirees may not always be the same as for state employees.

If you are retired from JRP or LRP and another state-sponsored retirement system, you may elect coverage through only one retirement system.

The amount, if any, that JRP or LRP contributes toward your health insurance premium depends upon your years of Kentucky governmental service credit. The maximum monthly contribution, as approved by the Kentucky Judicial Form Retirement System Board of Trustees and the percentage of payment, can be found in the JRP/LRP “Under Age-65 Memorandum” accompanying this handbook.

You will find the insurance premiums for each carrier on page 19. When choosing a plan, compare the premium to the chart above and the enclosed JRP/LRP Memorandum to determine how much JRP or LRP may contribute toward the plan you select.

Any portion of the insurance premium not paid by JRP/LRP will be deducted from your monthly retirement benefit. If the amount to be deducted is greater than your monthly benefit, JRP/LRP will bill you for any additional premium owed.

The insurance carrier's availability chart is located on pages 20-22. Please check closely to ensure that the carrier you have chosen is available **in the county where you live or, if applicable, a contiguous county (refer to pages 31-33).**

Provider directories are available from the individual insurance carriers which list their participating doctors, pharmacies, hospitals and the prescription drug formulary. Please check to make sure that your doctors, your pharmacy, and your hospital of choice are available to you through the carrier that you choose. Telephone numbers for the insurance carriers are listed on page 86.

Most of the questions you may have can be answered by reading this handbook and the enclosed JRP/LRP Memorandum. If you are unable to find answers to your questions, please contact the Office of the Kentucky Judicial Form Retirement System at (502) 564-5310.

Information for RETIREES of the Kentucky Retirement Systems

Retirees Who Return to Work

Retirees of the Kentucky Employees Retirement System (KERS), the State Police Retirement System (SPRS) or the County Employees Retirement System (CERS) who return to work with an agency that participates in the Public Employee Health Insurance Program may not cross-reference with themselves or elect coverage through the retirement system and put their employer contribution into a flexible spending account. Retirees who wish to participate in the Public Employee Health Insurance Program must choose to participate through the retirement system or the employer. Retirees must also waive coverage with either the retirement system or the employer, whichever is not selected to provide their health care coverage, at the time they return to work in a full-time status with an agency that participates in the Public Employee Health Insurance Program.

A beneficiary of a deceased hazardous duty retiree who is employed with an agency that participates in the Public Employee Health Insurance Program may only elect coverage through the retirement system or through his or her active employment. The beneficiary who wishes to participate in the Public Employee Health Insurance Program must choose coverage under the deceased retiree's account or elect coverage through employment and waive coverage on the other. This would also apply to beneficiaries of deceased retired legislators and judges who participated in the Kentucky Retirement Systems.

Kentucky Retirement Systems Benefits

If you are a retiree or a beneficiary receiving retirement benefits from the KERS, CERS or SPRS and are under age 65, you are eligible to apply for the health insurance coverage described in this handbook. You may also continue this coverage on your spouse or eligible dependents when they become eligible for Medicare until you become eligible for Medicare at age 65. The insurance carriers and plans offered in this handbook are the same for retirees and state employees. However, the administrative

procedures for retirees may not always be the same as for state employees.

If you are retired from the Kentucky Retirement Systems (KRS) and another state-sponsored retirement system, you may elect coverage through only one retirement system.

If you plan to cross-reference your insurance coverage with your spouse and you are unsure how the premiums will be handled, you should contact the KRS office before you complete the enclosed application.

The amount, if any, that KRS contributes toward your health insurance premium depends upon the amount of service credit you have with KRS and when that service credit was earned. In addition, the KRS contribution will be different for retirees who were employed in hazardous duty positions. **(If you are receiving monthly benefits as the beneficiary of a deceased, non-hazardous retiree, KRS will pay no portion of your monthly contribution.)** If you are receiving monthly benefits as the beneficiary of a deceased, hazardous duty retiree, KRS may pay all or a portion of your monthly contribution. The maximum monthly contribution, as approved by the KRS Board of Trustees, can be found in the KRS Insurance Notice accompanying this handbook. The following breakdown reflects the percentages of approved contributions that KRS will pay, if eligible, for current retirees and at the time of retirement for employees who were employed prior to July 1, 2003:

Years of Service with KRS	% of the Monthly Contribution Rate Paid by KRS
Less than 4 years (0-47 months)	0%
4-9 years (48-119 months)	25%
10-14 years (120-179 months)	50%
15-19 years (180-239 months)	75%
20 years or more (240 months or more)	100%

Under the provisions of House Bill 430 of the 2003 Session of the Kentucky General Assembly, new employees hired July 1, 2003 or after will be required to earn at least 120 months of service credit before they will be

eligible for insurance benefits at retirement. The percentage of the monthly insurance contribution paid for employees hired after July 1, 2003 is provided in the following breakdown:

Years of Service with KRS	% of the Monthly Contribution Rate Paid by KRS
Less than 10 years (0-119 months)	No Medical Benefits Available
10-14 years (120-179 months)	50%
15-19 years (180-239 months)	75%
20 years or more (240 months or more)	100%

The 120 month service requirement will be waived if the employee is disabled in the line of duty or killed in the line of duty. The provisions of House Bill 430 also allow the General Assembly to alter the level of insurance benefits for employees hired after July 1, 2003.

Those retired before August 1, 2003, as well as those who retire after August 1, 2003 with service credit in KERS, CERS or SPRS prior to July 2003 will not be effected by this legislation.

You will find the insurance premiums for each carrier on page 19. When choosing a plan, compare the premium to the chart above and the enclosed KRS Insurance Notice to determine how much KRS may contribute toward the plan you select.

Any portion of the insurance premium not paid by KRS will be deducted from your monthly retirement benefit. If the amount to be deducted is greater than your monthly benefit, KRS will bill you monthly for any additional premium owed.

Do not choose any coverage based on what you “hope” KRS will pay toward your premium. If you are uncertain about the amount the Kentucky Retirement Systems may pay toward the cost of your health insurance premium, you should contact the Kentucky Retirement Systems office. Your specific account information can only be discussed over the telephone if you have completed a Form 1000 and received a Personal Identification

Number (PIN) from the KRS office. The Form 1000 is available from our office or from our website at www.kyret.com.

This health insurance is not available to former spouses, nor is this health insurance available to Alternate payees being paid by KRS under the provisions of a qualified domestic relations order. Former spouses and Alternate payees may have rights to health insurance coverage under COBRA.

The insurance carrier's availability chart is located on pages 20-22. Please check closely to ensure that the carrier you have chosen is available **in the county where you live or, if applicable, a contiguous county (refer to pages 31-33).**

Provider directories are available from the individual insurance carriers which list their participating doctors, pharmacies, hospitals and the prescription drug formulary. Please check to make sure that your doctors, your pharmacy, and your hospital of choice are available to you through the carrier that you choose. Telephone numbers for the insurance carriers are listed on page 86.

During the Open Enrollment period our lines are always extremely busy. Please leave a message for a return call from a retirement counselor. Calls are returned in the order in which they are received, which may not be on the same day. Calling early during Open Enrollment will assist KRS in serving you better.

If you choose to participate in the Public Employee Health Insurance Program through the Kentucky Retirement Systems, **DO NOT** send your completed application to the Personnel Cabinet, OPEHI or directly to the insurance carrier. Doing so will delay processing of your application. All applications with "Kentucky Retirement Systems" printed on the top of page 1 should be returned to the address at the end of this section.

WARNING: Retirees living out-of-state and using out-of-network services under POS or PPO should be aware that they may be responsible for a greater portion of the doctor or hospital bills under these plans. The doctor or hospital may bill you for the amount that your insurance did not pay, in addition to the amount of your co-insurance. Your carrier's payment may be based on a fee schedule, which is used in Kentucky and could be less

than what is usually paid to providers in the state where you now live. For less cost to you, check with your insurance carrier to see if it has networks where you live and if you can access them.

Most of the questions you may have can be answered by reading this handbook and the enclosed KRS Insurance Notice. If you are unable to find answers to your questions, please contact the retirement office for assistance before completing the enclosed application.

Questions regarding benefits and applications for health insurance through the Kentucky Retirement Systems should be directed to:

**Kentucky Retirement Systems
Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601-6124
1-800-928-4646, ext. 4520 (if outside Franklin County, KY) or
502- 564-4646, ext. 4520 (if within Franklin County, KY)**

EXPLANATION OF KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS) BENEFITS

You are eligible for health insurance explained in this handbook if you are retired from KTRS, are under age 65 and meet the KTRS eligibility for insurance criteria. This is the same health insurance coverage offered to active teachers, Kentucky Retirement Systems retirees under age 65 and public employees.

The following general guidelines are offered to assist you in selecting your medical insurance coverage: 1) Check the availability chart on pages 20-22 to determine what plans are offered in your **county of residence or, if applicable, a contiguous county (refer to pages 31-33)**; 2) Look at the 2004 Rate Chart on page 19 for the plans available in your county; and 3) Check the carrier's participating provider information. Each carrier providing coverage in your county should send you a provider directory listing the participating hospitals and doctors. This provider directory will assist you in choosing your carrier. If you have not received your provider directory(s), you should contact the carrier(s) at the number(s) listed on page 86.

KTRS retirees are encouraged to contact the KTRS Call Center or a KTRS counselor if there are additional questions that have not been addressed in this handbook. A brief synopsis of KTRS retiree specific health insurance is offered on the following topics.

OUT-OF-STATE RETIREES

Retirees residing out of state may choose any POS or PPO offered by the state plan. If the carrier you select has a participating network where you live, you may be extended "in-network" benefits. Services obtained outside the network will be subject to "out-of-network" benefits. **It is strongly recommended that out-of-state retirees contact the carriers for further clarification of participating networks outside of Kentucky before making a choice.**

KTRS Supplement: Qualified retirees may receive a percentage of the KTRS contribution toward the cost of this insurance. If the cost of coverage is more than the KTRS supplement, the net amount will be deducted from

the annuity or billed if necessary. Retirees are not eligible to participate in flexible spending accounts.

Cross-Reference

Retired teachers will have the option to cross-reference with the state group. Please refer to the Health Insurance Handbook for further information.

Re-employed retirees

As a result of the 2003 Legislative Session, all KTRS retired members who waive their retirement annuity, or are eligible for medical coverage through the Public Employee Health Insurance Program, are required to WAIVE health insurance coverage through the Kentucky Teachers' Retirement System.

Retirees with Service in more than one Retirement System

You are eligible for one contribution toward the cost of insurance. If you have service in more than one retirement system, you should elect coverage through only one system and waive with the other.

Helpful Phone Numbers and Websites

Office of Public Employee Health Insurance (OPEHI)

1-888-581-8834

1-502-564-6534

<http://personnel.ky.gov/opehi.htm>

Bluegrass Family Health

1-800-787-2680

1-859-269-4475

www.bgfh.com

CHA Health

1-877-242-5978

1-859-232-8686

www.cha-health.com

Humana

1-800-448-6262

1-502-580-8100

www.humana.com

Kentucky Retirement System

1-800-928-4646

1-502-564-4646 ext. 4520

www.kyret.com

Kentucky Teachers' Retirement System

1-800-618-1687

1-502-573-3266

<http://www.ktrs.org/medical.htm>

Judicial/Legislators Retirement

1-502-564-5310

NOTES

This handbook was prepared by:

The Staff of
Kentucky Personnel Cabinet
Office of Public Employee Health Insurance
(OPEHI)



The Commonwealth of Kentucky does not discriminate on the basis of race, color, national origin, sex, age, disability, sexual orientation, gender identity, ancestry or veteran status. Reasonable accommodations are provided upon request.

This handbook is available in an accessible format upon request and is available on the Internet at:

<http://personnel.ky.gov/opehi.htm>

AN EQUAL OPPORTUNITY EMPLOYER M/F/D
Printed with State Funds